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MILITARY MEDICAL CARE SYSTEM

HEARINGS

BEFORE THE

SUBCOMMITTEE ON
MANPOWER AND PERSONNEL

OF THE

COMMITTEE ON ARMED SERVICES
UNITED STATES SENATE

NINETY-NINTH CONGRESS

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MILITARY MEDICAL CARE SYSTEM

THURSDAY, SEPTEMBER 19, 1985

U.S. SENATE,
SUBCOMMITTEE ON MANPOWER AND PERSONNEL,
COMMITTEE ON ARMED SERVICES,
Washington, DC.

The subcommittee met in open session, pursuant to notice, at 9:35 a.m., in room SR-232A, Russell Senate Office Building, Senator Pete Wilson (chairman) presiding.

Present: Senators Wilson, Thurmond, Denton, Nunn, Kennedy, and Glenn.

Staff present: Arnold L. Punaro, staff director for the minority, and Patrick A. Tucker, counsel; Patricia L. Watson, research assistant; David S. Lyles, professional staff member; Mary J. Kampo and Richelle M. Turner, staff assistants.

Also present: Mark J. Albrecht, assistant to Senator Wilson; Allan W. Cameron, assistant to Senator Denton; Jeffrey B. Subko, assistant to Senator Exon; Gregory B. Craig, assistant to Senator Kennedy; Edward McGaffigan, Jr., assistant to Senator Bingaman; and Phillip P. Upschulte, assistant to Senator Glenn.

OPENING STATEMENT BY SENATOR PETE WILSON, CHAIRMAN

Senator WILSON. If there are any in the audience who are here because of their interest in the porn rock hearings, this is not the place.

Senator NUNN. We hope.

Senator WILSON. Yes; it is early in the hearing.

Senator GLENN. I hope you gentlemen brought some good records with you this morning.

Senator WILSON. Good morning, ladies and gentlemen, this is a meeting of the Manpower and Personnel Subcommittee of the Senate Armed Service Committee and this morning we are holding a hearing on wartime medical readiness.

With me are the distinguished ranking member of the subcommittee, Senator Glenn of Ohio, and the distinguished ranking member of the full committee, Senator Nunn of Georgia. Both of them share my interest in this area.

We are expecting others to appear. We have been notified that if the schedule permits, they will be with us.

The subcommittee meets this morning to conduct the first in a series of oversight hearings on the military health care system. It has been more than 3 years since this subcommittee had the opportunity to focus specifically on the status of the military medical system.

During that period there have been a number of problems in that system which have either been identified in internal Department of Defense audits or investigations, been reported in the press or have been brought to the attention of the subcommittee. Among these problems have been the:

Serious shortcomings in the wartime medical capability of our Armed Forces is best evidenced by the estimate of the Assistant Secretary of Defense for Health Affairs that in the event of a full-scale conventional conflict only 20 percent to 25 percent of our young men and women in the Armed Forces who would be wounded could be provided with needed surgical care;

The failure of two recent Surgeons General to take appropriate actions when serious allegations involved patient care were raised about senior physicians under their supervision;

The August 1985 finding by the Department of Defense inspector general that of six reserve programs directed by the Secretary of Defense to be implemented in 1983 to overcome the serious medical personnel and readiness shortfalls in the reserve components, only one of those six programs has been implemented by the services;

The findings in April 1984 by the Medical Readiness Review Group, composed of uniformed personnel, which I believe can be fairly characterized as failures within the U.S. European Command to have or to pursue an integrated and unified wartime medical plan;

The recent Department of Defense survey which found continued and widespread dissatisfaction by the users of the peacetime military medical system; and

The failure of the services to execute and require full compliance from the field of Department of Defense directives on credentialing, quality assurance and risk management procedures which if in place and being enforced might have spared the military medical system and its users the terrible results of cases such as that of Dr. Billig at Bethesda Naval Hospital, that of Dr. Watzinger at Keesler Air Force Hospital, and that of Abraham Asante at Walson Army Hospital at Fort Dix.

Because of some of these very incidents, Senator Nunn, the ranking member of the full committee and a member of this subcommittee, formally requested oversight hearings of this subcommittee on the whole military medical system. Such oversight hearings were already on the agenda of the subcommittee and I fully concurred in Senator Nunn's request.

For these reasons we meet this morning to focus on the primary mission of the military health care system providing wartime medical care.

Our second hearing will be next Tuesday morning, September 24 beginning at 9:30 a.m., in room 232 of this building. At that hearing we will begin our look at the peacetime military health care delivery system.

I anticipate that there will be additional hearings. We have not yet set specific dates, but hope to do so by our meeting next Tuesday. The additional meetings will allow us to hold hearings on specific legislative proposals introduced this year by our colleagues that relate to the delivery of the health care system.

At least one of these hearings, and there might be more than one, will focus on those bills and on any related legislative proposals affecting military health care.

This morning we have as our witnesses:

Hon. William Mayer, Assistant Secretary of Defense for Health Affairs.

Maj. Gen. Francis Toner, Deputy Director for Strategic Mobility, Directorate of Logistics, J-4, Organization of the Joint Chiefs of Staff.

Lt. Gen. Quinn Becker, the Surgeon General, U.S. Army.

Vice Adm. L.H. Seaton, the Surgeon General, U.S. Navy.

Lt. Gen. Murphy Chesney, the Surgeon General, U.S. Air Force.

Gentlemen, I welcome each of you here today. Your prepared statements, both classified and unclassified versions, will be included in the hearing record with proper regard for the classified information contained in them. I, therefore, invite you to summarize your statements so that we can move on to questioning.

Additionally, the subcommittee is prepared to go into closed session later in this hearing to receive any classified testimony you may wish to provide and to permit you to answer questions which require classified information.

If questions should be asked in open session which require classified information to answer, I ask that you merely indicate that you will provide the answer in closed session.

Before hearing your statements, I will ask Senator Glenn, the ranking member of the subcommittee for any opening statement he wishes to make.

Senator GLENN. Thank you very much, Mr. Chairman.

Just a brief statement. I am truly very pleased you have called these hearings because I think they are long overdue. I am glad we are beginning this series of oversight hearings on medical care in the Department of Defense.

I have a personal interest in this, too. I speft a long time in the military myself. So, I come as a user of the system albeit quite a few years removed from that system now. I am familiar with depending on the military medical system in wartime as well as the family use of that system which is part of the military contract in effect with each person who goes into the military service.

I think that ensuring that the military health care system consistently provides the highest quality of care is one of the most important oversight responsibilities of this subcommittee. It may not be quite as sexy as a lot of other things. We don't have the huge crowds of television crews here with us this morning. That is all down the hall in the porn area that the chairman alluded to when we started this. Not as much attention is given to F-15's and carriers and shoulder-fired Stinger missiles and things like that.

So, we need more attention on it. One of the things that concerns me very much is that many of these deficiencies in the military medical care system, whether wartime or peacetime, we have known for many years. Many of these things are not brand new. It concerns me very much that we have not had the will, method, or budget, or whatever, to make certain that these deficiencies were corrected.

So, I am glad we are getting into this. The press has been full of stories about problems with the military health care system. I think you will agree that some of the problems have been overstated. Some of them are very, very real problems that need to be addressed seriously by the Defense Department.

One of the difficulties, I think, has been in classification. I was somewhat appalled by some of the statements here, for instance, where the whole page was stamped unclassified, but paragraphs on that page were marked secret. That is a little bit dingaling, you will agree.

I don't know whether this is a cover-your-tracks operation because some of the reports we got over here for committee use were originally unclassified reports. When we requested them for the hearing, suddenly they were classified. That concerns me and should concern the press, it should concern the military people in our commands.

Most of the things I read were not really that secret or classified. At least I didn't judge them to be. Maybe you gentlemen are in a better position to make those judgments than I am.

One of the biggest potential problems that we have in the Pentagon is in this area of military medical care because we have so many people who depend on the military health care system in peacetime or wartime and we don't want them to lose confidence in that system.

If this were to happen in peacetime, it would be a serious breach of faith on our part. Military members expect and have every right to expect quality medical care for themselves and their families, whether peacetime or wartime. That is part of the contract we make with people coming into the military.

In wartime the consequences of such a loss of confidence could be catastrophic. If we cannot assure our soldiers they will receive adequate combat medical care, it might even have a decisive effect on their ability to sustain their will to fight.

Mr. Chairman, I think it is very appropriate that our first oversight hearing on military health care should be focused on wartime medical care capability. The military medical care system has been an important peacetime mission to provide quality care, but the wartime medical system is the reason for the existence of the military system. That comes first.

I welcome our witnesses this morning. I will close with a portion of the final paragraph in the Zimble report because I think it is a very good summary of this thing. Part of that final paragraph says:

> It has been the American tradition to provide care for our wounded in time of war. Hictorically, this has had practical benefits. The certainty that care was available has motivated troops to fight and medical systems have returned many combat-hardened personnel to their units.
>
> It also defines the kind of people we are. If we fail now to provide for our potential future casualties, we will do more than risk combat effectiveness. We will fundamentally change ourselves.

Thank you.

Senator WILSON. Thank you very much, Senator Glenn.

Senator Nunn, would you care to make a statement?

Senator NUNN. Briefly, Mr. Chairman.

I want to thank you for having these hearings. I think they are very important. I know that you and Senator Glenn have done an awful lot in preparing for them, and I am grateful for that.

I have a couple of observations.

First, I think the fact that we are having these oversight hearings emphasizes the importance of congressional oversight, not only in this area, but overall.

One of the things that is most frustrating to me in this whole process we are now in is the yearly authorization. We have discussed this time and time again. We are so busy with the yearly budget process and the authorization, for instance, in this subcommittee, which I had the honor of chairing and being ranking member also during the seventies. Each year we authorize the numbers for the military services, and so on, which is important, but I would contend it does not have to be done every year.

It could be done over a long frame of time. We don't have time to get to key issues like this which deserve our attention. I think this hearing is timely. I know in the overall crunch of other things, it is hard to schedule, but I appreciate very much your doing that.

Second, Senator Glenn, your opening statement has outlined the problems that have come up. I think we need to distinguish between two types of problems.

One type would be the question of capabilities of the medical personnel themselves. That gets into the allegations that have been made about certain activities in various places even around the Washington area, the issue of whether the medical personnel are qualified.

In my opinion, the vast majority are well qualified. The incidents where poor medical service has been delivered, where there have been allegations of negligence, those are very disturbing and we need to zero in on them. I think the perspective needs to be maintained and most of our people out there are hardworking and very well qualified in those areas.

The second is a broader focus and that seems to me to be the system itself. You can have very good dedicated, skilled personnel out working and the system itself can be so flawed that their efforts are not fully productive. It is that second failure that I think we need to zero in on.

If the first part of the question of negligence is being handled adequately by the executive branch itself, it seems to me that is a case-by-case examination and while it lends itself to oversight, it doesn't lend itself to, in my opinion, a case-by-case congressional examination.

I don't think that is our job. But the system itself is our job in terms of overall direction. So, my questions today will primarily be directed at the system itself.

When you get reports like Admiral Zimble's report, quoting from that on the Beirut disaster that we had in terms of the Marines there, he states and I quote, in the medical planning report:

> All those who have reviewed the events of October 23 agree that had the ratio of killed outright and wounded been revised so that over 200 casualties required treatment rather than fewer than 100, the medical system might well have failed.

That is 200 people. If we got involved in the Middle East scenario which we have as one of our contingency plans, and everything went almost perfectly in any kind of battle, you would still be talking about thousands of people that would need medical treatment.

If 200 people could have overloaded the system in the Middle East, you have to ask what would have happened if we had had to go in and really fight a battle there that involved a lot of casualties.

Senator THURMOND. Senator Nunn, will you yield for a half a second?

Senator NUNN. I will be delighted.

Senator THURMOND. Mr. Chairman, I have to go open the Senate.

I want to compliment these gentlemen for the fine job they are doing and ask unanimous consent that my statement appear in the record.

I have to conduct a hearing in the Judiciary this morning and I have to leave.

Thank you very much Senator Nunn.

Senator NUNN. Certainly, Senator Thurmond.

Senator WILSON. Without objection, your statement will be inserted in the record following Senator Nunn's remarks.

Senator NUNN. Mr. Chairman, sometimes I go longer on unprepared statements than prepared. I apologize.

The European Command is another situation. There I think the problems which have been so obviously pointed out in some of these reports, and that we will talk about today, are critical.

If our personnel stationed in Europe in peacetime don't have confidence that if they are called on to fight a war, if they are wounded, they are going to be cared for as best we can. In battle conditions, it is always difficult. If they don't have that confidence, then it severely undermines their ability to fight and our overall deterrence of war, which, of course, is what it is all about.

Also, we have to advocate the idea that in Europe the problem is not just one of medical care. It is much broader than that. The problems that are broader than that are beyond the scope of the witnesses' responsibilities. That is, how do we evacuate the dependents in Europe?

Every time I bring this up somebody screams and hollers and says, "Nunn wants to withdraw dependents from Europe and undermine morale," and all that.

I don't. I know the importance of families being in proximity to our dedicated personnel. But I also know that if we get into a war in Europe, we have a mammoth problem in terms of getting supplies in, roads being jammed, dependents not having ways to get out.

The medical problems themselves have to be folded into that scope. We could solve the European medical problem supposedly on paper in terms of adequate personnel, but unless that overall dependent evacuation problem can be addressed seriously, which, in my opinion, through three administrations, it never has been, then we aren't even beginning to cope with the real problem in Europe.

Mr. Chairman, I don't suggest we solve all these problems this morning, but I do believe that the scope of the problem is serious

and I think that you are to be commended for directing our attention to it.

I thank the witnesses for being here. I will have some questions which are rather pointed, but they won't be aimed at anyone individually, but rather at the system as it now exists.

Senator WILSON. Thank you very much, Senator Nunn.

The prepared statement of Senator Thurmond will be inserted in the record at this point.

[The prepared statement of Senator Thurmond follows:]

PREPARED STATEMENT BY SENATOR STROM THURMOND

Mr. Chairman: I want to thank you for having today's hearing. Medical readiness is every bit as important as equipment readiness. I would also like to welcome our witnesses to these proceedings. Gentlemen, we have made a great deal of progress in recent years in improving our military in every area except wartime medical readiness.

Many lives were saved in Vietnam because of rapid evacuation and treatment procedures, but our involvement in that conflict was gradual. Additionally, it was a low intensity conflict. We had complete air superiority, and our adversary was incapable of matching our firepower on the battlefield.

By contrast, any war with the Soviets will be a high intensity conventional, and possibly, nuclear war. Our casualty rates would be enormous. The 1973 Arab-Israeli War was a high intensity conventional conflict. It is my understanding that the Israeli casualties in that conflict equated to the United States losing more personnel than were killed throughout the Vietnam War, and the Arab-Israeli War lasted only a matter of weeks without the use of chemical or nuclear weapons.

I am very concerned about medical readiness, and I sincerely want to work with the Department of Defense to correct our deficiencies as soon as possible. Thank you, Mr. Chairman.

Senator WILSON. Our first witness this morning will be Dr. William Mayer, the Assistant Secretary of Defense for Health Affairs.

His curriculum vitae is long. It is distinguished. It is by itself fascinating reading.

In the interest of hearing from him rather than about him, I will simply note it for the record and say that we are delighted to have him with us and welcome his testimony.

STATEMENT OF HON. WILLIAM MAYER, M.D., ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

Dr. MAYER. Thank you, Mr. Chairman.

Mr. Chairman, Senator Nunn, Senator Glenn, I know I speak for all of my colleagues at this table in telling you that it is a real privilege to appear here before those Members of the Senate who have distinguished themselves over the years in their interest and information and knowledge and support to the defense of this Nation.

We are happy to have the opportunity to discuss the matter that we exist primarily to address. I will attempt in this brief period to summarize the kinds of things that are incorporated in my statement.

STUDIES OF MEDICAL READINESS CAPABILITY

As you know, Secretary Weinberger ordered extensive field studies done last year of our medical readiness capability. A major study done in Europe was the Zimble report—that study from

which we have heard quotations this morning. A similar study was conducted of the Pacific Command.

This review actually constituted the most extensive review of medical readiness that has ever been undertaken. It focuses on the need to improve cross service medical readiness planning and to increase the resources that are available to support medical readiness requirements. There were nearly 100 specific recommendations that emerged from these two studies.

These recommendations for corrective action were directed at all levels within the command structure, within all the services, the Office of the Joint Chiefs and the Office of the Secretary. The vast majority of these recommendations have been acted upon. Many of them have been successfully completed.

I would like to emphasize that each of the services really moved out and addressed the recommendations in a serious, determined, vigorous fashion and I think you will hear from the statements of the three Surgeons General that some real progress has been made.

RESULTS OF REVIEWS

The tangible results of the reviews, the first really major tangible results, were a significant increase in the resources committed by the Department of Defense to procure deployable medical systems.

The budget request contains over $500 million in various appropriations for this purpose.

In addition, we have successfully directed the reallocation of approximately $2 billion between now and 1990 to support the medical readiness efforts. We expect to be at our full requirement level by that time. These dollars won't only fund the deployable equipment we need, but also the people, the facilities, the supplies and other support costs associated with deployable medical systems.

Our line commanders in this have developed a much stronger interest in medical support than ever before, partly as a result of a number of medical exercises, general exercises, that were conducted worldwide that helped illustrate along with the EUCOM and PACOM reports that there were significant measures that needed to be taken.

We are also actively seeking to relocate stored mobilization hospitals and equipment at or near their intended deployment sites and to have them in a turnkey or standby mode. This is especially critical when one considers the tremendous number of aircraft needed to transport just one field hospital.

It takes 28 C–141's to move a 500-bed field hospital. It takes 65 C–130's to move one. In time of major military emergency, it is unlikely that we can have anything like that number of aircraft allocated to our use when the top priorities will be transport of ammunition and soldiers and equipment for fighting a war.

Just this last fall during the Reforger exercise, the return of forces to Germany which occurs annually, I had the opportunity to witness several of these pre-positioned facilities in action, staffed both by active duty people and reservists, who were called for active duty.

I think the measure of the increased awareness of the importance of this entire undertaking in medical readiness is the fact that this year for the first time after only spotty ability of our reserve physicians to turn up for a couple of weeks and be deployed overseas, this year we had a tremendous increase in the number of doctors who did appear at Reforger, were sent overseas and went through the exercise.

I was very impressed with the fact that our peacetime medical force was gaining the valuable training it needs while at the same time maintaining operational readiness.

FUNDING FOR MEDICAL READINESS

I am pleased that we have a very successful campaign within the Pentagon to get the attention of the senior military officials and the Joint and Unified Commanders and have gotten support for allocating more funds to medical readiness, both in the budget year and in the 5-year defense plan than we have ever been able to accomplish before.

We find that they were really supportive. That has come out, therefore, in the budget that was sent to the Congress.

What is dismaying is that I learned the day before yesterday that the Military Construction Committee of the House Appropriations Committee eliminated every single one of the military construction projects that are specifically related to our medical readiness, which would include, for example, such things as the place to put, and I am not talking about building little Walter Reeds around the world, but the place to put stored fleet hospital support facilities in Guam—cut out—a fleet hospital support facility in London—cut out—a medical contingency complex at Torrejon Air Force Base in Spain which we badly needed—cut out—a medical contingency complex, which is the most important contribution we could make in medical readiness in the whole Korean Peninsula at Kimhae was cut from the budget, as in the past when this requirement was slipped within the Pentagon to slide that a bit in the future.

We finally got their attention. We finally got the money, but the subcommittee has cut it out. The contingency complex in Korea, Kimhae, is adjacent to the airfield at Pusan, well down the peninsula, out of the immediate target area in case the North Koreans started anything and would have provided us 500 beds; also, an Air Force facility, a warehouse storage construction project, not a hospital, but one which is designed so that the equipment could be set up and used as a hospital; and an adjoining facility that is a 250-bed aeromedical staging facility which we would badly need in case of outbreak of hostilities there.

When you realize that in spite of the 40,000 or 50,000 American troops in Korea, we only have 140 beds set up and operating, you can see why we think that the Kimhae project is so terribly important.

There was also a medical contingency complex in Turkey that was cut from the budget. That was all American military medical construction specifically related to overseas readiness.

HOSPITAL SHIPS

One element of our readiness program of which we can all be very proud indeed is the development by the Navy of the two hospital ships. They are both in San Diego at the National Shipyard Co., there. They are ahead of schedule.

The first, *Mercy,* may be ready in as little as 1 year from now and the other a few months later, perhaps 6 months later. Those ships are 1,000-bed state of the art general, acute surgical hospitals with 12 operating rooms and capability to deliver care on a scale and quality that has never before been possible in this country.

HOST NATION SUPPORT

We have also increased our efforts in obtaining host nation support. While I cannot go into details in open session, I will be happy to tell you of the success we have been achieving in that area.

Host nation support is obviously very important in the case of outbreak of hostilities. We have to be realistic, however, and realize that, for example, in a major ground conflict in Europe, the host nation support that we might need might be very desperately needed by the host nation itself, both for military and civilian casualties. So, we can't rely totally on that.

We do have relationships with many of the countries in Europe and elsewhere to help us in our host need to allow us to get our people in place and take over total medical care.

AEROMEDICAL EVACUATION

Aeromedical evacuation has been a subject of great concern in both of the studies that I spoke of. We do not have a large number of dedicated C–9 Nightingale aircraft. It is possible, and we have kits, to convert other large airplanes, particularly the C–141 and C–130, for patient carrying responsibility, but the entire issue of aeromedical evacuation is being very intensively studied by the Air Military Lift Command working closely with the European Command. Their report, steering us in the direction we should go with respect to evacuation, will be out soon. We will study it very carefully.

It has to be remembered, however, that even though we can get very good at evacuating patients, we begin to defeat a major purpose of the health services if we overevacuate from the theater of operation.

A major source of replacements during the early phases of any war is the medical system and how well they are able to return people to duty. If we take too much advantage of this splendid capability that the Air Force can offer us in moving patients out, we tend to risk overevacuation.

MEDICAL COMMUNICATIONS

Medical communications continues to be a major flaw, in my judgment, in our medical readiness capability. First, there is no dedicated medical communications system. There is no medical network. That means that within the services, field units and medical

units have to get on the net in order of priorities determined not by them.

It is difficult many times to communicate through the different systems and equipment that the different services use. This whole issue is being explored very seriously.

MEDICAL LOGISTICS SYSTEM

The European Command, working with my staff and with the service Surgeons General's staffs, is examining the feasibility of establishing a single, integrated medical logistics supply system in Europe.

The medical logistics systems are separate within the three services; the methods of obtaining things are different, and there is a great need to be able to share readily the medical support that exists.

In that connection, I can report success in a very difficult undertaking of standardizing to the satisfaction, not total ever, but to the satisfaction of each of the services, standardizing deployable medical gear.

We have standardized sets of equipment now which form the basis for our hospital modules that can be used by any branch of service. It will be equipment that everyone is familiar with, that they have trained on, and that they can use regardless of who originated it.

AREAS OF CONCERN

These are very significant steps in medical readiness. I am very pleased with these. The fact is, though, that there are areas I am not pleased with, in which progress has not been satisfactory.

UNITY OF COMMAND

The basic principle of military operation is unity of command. There is no unity of command in the sense of a senior flag or general officer who is in overall charge and adequately staffed to be in overall charge full time in either the European theater or in the Pacific theater—a full-time medical officer who can oversee the cross service planning that is necessary, the training that is necessary, who in times of emergency can actually assume directive control of medical elements in those theaters of operation.

The recommendation was made over 1 year ago that such flag and general officers be designated for those jobs. It has never been possible, although we have an agreement in principle from the Joint Chiefs who support the idea, and the idea is supported by the Secretary; but it has not been possible to identify the two general or flag officers necessary for that absolutely critical command position.

We are seeing work done now as additional duty by one of the European Command's surgeons and for the moment it is progressing very nicely, but it will never be adequately done when it can only be a part-time job and especially in a war.

COMMON MEDICAL MANPOWER METHODOLOGY

Finally, development of a common methodology for predicting military requirements for manpower, a matter of great concern to this committee, has been a high priority of mine since I took office.

I am pleased to say we are beginning to approach a final solution to that problem. In the past, each of the services necessarily and historically have used different methods for estimating the manpower required to perform a given workload.

It is critical that manpower allocation decisions be made on the basis of their contribution to wartime readiness and that these decisions be made in a consistent, reasonable and logical way. I think we are approaching this.

To the extent practicable, I intend to apply this policy during our upcoming review of the service budgets for fiscal year 1987.

BLUE RIBBON PANEL ON SIZING MILITARY TREATMENT FACILITIES

I know you are aware there was a Blue Ribbon Panel convened at the behest of the Congress to examine the methods we use to determine the size of military treatment facilities. That panel, made up of distinguished civilians, people from the medical and aligned professions, came to the conclusion, and stated very forcefully, that the overriding importance in all our determinations must be medical readiness.

This was contrary to some of our anxieties in which we felt that maybe the civilians involved in the large growing health care industry in America might try to say that all our decisions should be based on cost-effectiveness.

There is nothing very cost effective about preparing for war. It is wasteful and it does require expenditures far beyond what is necessary just to conduct day-to-day business. But the panel did not recommend cost effectiveness be the primary criterion.

The panel said the most important thing we should use in determining how big or where or how we will staff a medical facility is the requirement that we be medically ready to accomplish our primary mission, which is the care of uniformed people at a time of war.

The panel recognized that the problems of access to medical facilities should be used in determining size and also that legitimate training and graduate needs have to be taken into account.

Secretary Weinberger has fully endorsed the Blue Ribbon Panel's recommendations and we in Health Affairs and in the services are moving to implement all of its recommendations without delay.

This implementation will result for the first time in coordinated and centralized management of all military medical construction and design.

CONCLUSION

Mr. Chairman, in conclusion, since coming to the Department 2 years ago, I have devoted my energies to three things:

Improving the readiness of our medical system, the quality of care it provides in wartime and peacetime, and the cost effectiveness of the entire system. There are just so many public resources

that we can spend. We have made progress in all three areas. The services, the Surgeons General and their staffs have been very supportive in much that we are doing. We will often argue among ourselves as to the best way to do things, but we are all aiming at the same goal and in the minds of each of us, readiness is our primary consideration.

One thing that becomes clear to me is that our reliance on our direct care system to accomplish both our total medical readiness mission and also the enormous peacetime mission that we have in caring for four times as many nonuniform people as we do uniformed people has placed significant stress on our ability to accomplish either mission satisfactorily.

I believe our greatest challenges during the next several years are:

First, to sort out our wartime readiness mission and our peacetime benefit mission.

Second, to improve substantially our ability to utilize civilian health care resources to meet a larger portion of our peacetime benefit demand.

And third, to accelerate the redirection of our military direct care system to effectuate our top priority commitment to medical readiness.

Meeting these challenges will likely require some departures from traditional methods of operation. If so, we will have to be ready to make such departures.

I want to assure you that our reason for being, in my judgment, is to be ready to go to war as medical soldiers and do the job of taking care of our most precious national asset and that is our people, the very least that we owe to those young people that we ask to risk their lives in defending this country.

Thank you very much for your attention.

[The prepared statement of Dr. Mayer follows:]

PREPARED STATEMENT BY HON. WILLIAM MAYER, M.D., ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

Mr. Chairman, members of the subcommittee, I am pleased to have this opportunity to appear before you today to discuss the Department of Defense's efforts regarding medical readiness. With me today are Major General Frances Toner, representing the Office of the Joint Chiefs of Staff, and the three Surgeons General: Lt. Gen. Quinn Becker from the Army; Vice Adm. Lewis Seaton from the Navy; and, from the Air Force, Lt. Gen. Murphy Chesney. Recognizing that we will be meeting again next week to discuss our peacetime system, I would like to begin today with a brief overview of the size and scope of the Department's medical activities in order to provide a framework within which to examine medical readiness.

OVERVIEW

The fiscal year 1986 budget request for military medical operations is over $9.6 billion. This includes approximately $3.4 billion for the Army, $2.1 billion for the Navy, and $2.5 billion for the Air Force. Also included is nearly $1.5 billion for CHAMPUS, and $97 million for Medical Information Systems.

Nine point six billion dollars is an impressive sum of money, and the medical system which these dollars support is equally impressive. We operate over 500 facilities, worldwide, including 168 hospitals. These are staffed by over 170,000 physicians, nurses, administrators, medical corpsmen and other support personnel. On any given day, some 23,500 beneficiaries will be inpatients in these hospitals or under CHAMPUS and during the course of the year we will provide over 56 million outpatient treatments, and process more than 5 million claims from civilian providers.

The vast majority of our budget request goes to support our enormous day to day responsibilities for health care for nearly ten million people. This peacetime activity does, of course, play an important role in supporting our readiness mission. In addition, this year our request includes over half a billion dollars dedicated solely to improving our medical readiness posture. This represents a sizeable increase over previous requests.

MEDICAL READINESS OVERVIEW

Last year, Secretary Weinberger ordered extensive field reviews of our overall medical readiness capability, both in Europe and the Pacific. A special review group conducted a thorough investigation into the areas of medical evacuation, medical command and control, medical communications, and medical planning.

These reviews constituted the most extensive analysis of medical readiness ever conducted and resulted in a great deal of attention being focused on the need to improve cross-service medical readiness planning and increase the resources available to support medical readiness requirements. The European and Pacific reviews contained nearly 100 specific recommendations for corrective action. These were directed at all levels within the command structure, the Services, the Office of the Joint Chiefs of Staff, and the Office of the Secretary of Defense. The vast majority of these recommendations have been acted upon, and a number of offices and individuals, particularly in the commands, deserve credit for their efforts.

DEPLOYABLE MEDICAL SYSTEMS

One tangible result of these reviews is a significant increase in resources committed to procuring deployable medical systems. As I mentioned earlier, this year's budget request contains over $500 million in various appropriations for this purpose. In addition, we have successfully directed the reallocation of nearly two billion dollars programed between now and fiscal year 1990 to support the medical readiness effort and expect to be at our full requirement level by that time. These dollars will fund not only the deployable equipment we need, but also the people, facilities, supplies, and other support costs associated with deployable medical systems.

I recognize, though, that items programmed for 1990 provide no help today, and so we have taken a number of steps to make what is or will soon be on hand more accessible. We are actively seeking to relocate stored mobilization hospitals at or near their intended deployment sites and have them in a turnkey or standby mode. This is especially critical when one considers the tremendous number of aircraft needed to transport just one of these hospitals. During Reforger exercises this past Fall I witnessed several of these facilities in action, staffed by both active and reserve components flown over from the United States, and was impressed by the fact that our peacetime medical force was gaining valuable training while at the same time maintaining the operational readiness of deployed medical assets.

HOSPITAL SHIP PROGRAM

Another element of our medical readiness program of which we can all be proud is the hospital ship program. Two San Clemente-class tankers are presently being converted into floating general hospitals with 1,000 beds and 12 operating rooms each. The USNS *Mercy* is now in a San Diego shipyard with conversion well underway and conversion of the USNS *Comfort* is scheduled to begin soon.

HOST NATION SUPPORT

We have also increased our efforts at obtaining host nation support, not only in the area of land and facilities, but also making arrangements for interim assistance in hands-on medical care until our deployable facilities become operational and for patient transportation assistance, such as dedicated hospital trains. While the exact nature of these support agreements and the parties involved are classified, I can say that we have made substantial progress over the past two years at establishing new agreements and clarifying existing ones.

AEROMEDICAL EVACUATION CAPABILITY

The Military Airlift Command is working more closely with the European Command to determine the extent of their medical requirements and how MAC can best serve them. MAC is seeking ways to increase the number of patients a C-141 will carry; reexamining the flying routes and time tables showing when patients may be transported; and, exploring the feasibility of dedicating additional aircraft to aero-

medical evacuation. In November of this year, an interim automated patient evacuation system should be operational to better assimilate the massive patient data which flows in on a daily basis.

COMMUNICATIONS

Each of the Services has methods of communication between Commands, units, aircraft, and vessels. The means of communication vary from land lines to satellites and vary from Service to Service. Our medical personnel often cannot communicate across Service lines due to differences in equipment and procedures. I do not yet know the full extent of this communications problem, but I plan to examine it and explore the feasibility of a dedicated medical communications capability.

LOGISTICS

The European Command, working with my staff, is examining the feasibility of establishing a single, integrated medical logistics system in Europe. Such a concept was recommended by the European Command Review I mentioned earlier. I intend to examine their findings carefully and make a decision on this issue as soon as they are available. Our equipment standardization efforts remain on track. Currently, we are developing plans which will insure that modules for our deployable systems are properly stored to meet mission requirements and to satisfy maintenance functions.

While I am pleased with these significant steps, there are other problem areas in which satisfactory progress has not been made. Primarily, I am concerned that only small gains have been made in integrated, cross-service medical readiness planning, and by the differences among the Services' methods of predicting wartime medical manpower requirements.

MEDICAL READINESS PLANNING

More than a year and and a half ago, the report accompanying the review of medical readiness in the European Command contained a number of specific recommendations regarding planning activities. These included: providing adequate medical planning staffs; reconciling inconsistencies in planning and procedures for the control and use of the aeromedical evacuation system in wartime; establishing joint command and control over medical planning and medical resources; directing joint utilization of medical resources in wartime; and developing joint medical plans for dealing with terrorist attacks. This past Spring, the U.S. European Command held a conference on medical planning to address many of the recommendations cited by the review group. I attended that conference and was pleased that it resulted in the identification of six major objectives to partially address the problems outlined in the report. Although a great deal of discussion has taken place in this area over the past year and a half, to date few definitive actions have been taken.

I do not consider this rate of progress acceptable, but must admit that I have not been very successful in altering it. To a large extent our problems stem from much larger issues dealing with how the Unified Commands relate to the individual Services and how the Office of the Secretary of Defense, in general, and the Assistant Secretary for Health Affairs, in particular, relate to the Military Departments. To address the issue of how the unified commands relate to the individual Services, I have recommended strongly, with Secretary Weinberger's support, that the Command Surgeon in Europe be a full-time flag officer with clear authority to review and oversee joint medical planning for all three Services. Regarding the relationship between my office and the Services, Secretary Weinberger has recently delegated to the Assistant Secretary for Health Affairs the authority to serve as program manager for all DoD health and medical resources. I am confident that this will facilitate our progress.

PREDICTING MANPOWER REQUIREMENTS

Development of a common methodology for predicting wartime requirements for medical manpower has been a high priority of mine for some time and, I am pleased to say, we are finally approaching a resolution. In the past, each of the Services used fundamentally different methods to estimate the manpower required to perform a given workload. For example, to staff 1,000 wartime hospital beds in the United States, the Army predicted it would require 106 physicians, the Air Force 166, and the Navy 392. These disparities could not be adequately reconciled to permit the development of either effective mobilization plans or balanced manpower programs.

The obvious problems generated by these differences have been recognized since 1978 yet have proven extremely difficult to rectify. However, efforts to design a standardized, workload-based methodology for predicting requirements have been productive and have resulted in the development of a computerized model, the Medical Planning Module (MPM) of the Joint Operation Planning System (JOPS). Some improvements are required in the data base before it will be capable of predicting the full range of wartime medical requirements, but it clearly contains the correct logic for making those predictions.

To correct this situation, I have directed that the necessary additions be made to the Medical Planning Module (MPM) data base and that all three Services utilize it in developing future requirement submissions. This policy is now in force.

It is critical that manpower allocation decisions be made on the basis of their contribution to wartime readiness. I intend to direct the Services to develop peacetime medical force structures that are as close as possible to wartime requirements. This will include all facets of the force structure development process to include total force specialty mix, all training programs, recruiting and retention efforts and other accession plans. To the extent practicable, I intend to apply this policy during our upcoming review of the Service budgets for Fiscal Year 1987.

BLUE RIBBON PANEL ON SIZING

The recently completed Report of the Blue Ribbon Panel on Sizing DoD Medical Treatment Facilities also recognized the overriding importance of medical readiness. One of the Panel's principal recommendations was that medical readiness be the primary criterion for determining the size and composition of the entire peacetime active duty medical force and of all facilities and workload in our direct care system. The Panel also advocated the establishment of firm guidelines to ensure that future facilities planning efforts be consistent with our readiness mission. Secretary Weinberger has fully endorsed the Blue Ribbon Panel's recommendations and we in Health Affairs are moving to implement all of its recommendations without delay. This implementation will result in, for the first time, coordinated and centralized management of all military medical construction and design.

CONCLUSION

Mr. Chairman, since coming to the Department some two years ago, I have devoted my energies to three things: improving the readiness of our medical system, the quality of care it provides in wartime and peacetime, and the cost-effectiveness of the entire system. We have made progress in all three areas, though much more remains to be accomplished. One thing that has become clear to me is that our reliance on our direct care system to accomplish both our wartime readiness and peacetime benefit mission has placed significant strains on our ability to accomplish either effectively.

Pressed by a demand to provide comprehensive health care to some 10 million beneficiaries, we have not been able to assure top priority to wartime readiness. Thus, our force structure does not meet our wartime requirements either in number or mix. Our training programs fail to adequately address these manpower priorities. Our peacetime benefit mission presents a workload largely irrelevant to developing and maintaining specialty skills necessary for wartime readiness. And, finally, our civilian care services such as CHAMPUS are too costly and do not take sufficient advantage of competition in the civilian health care marketplace.

I believe our greatest challenges during the next several years are: first, to sort out our wartime readiness mission and our peacetime benefit mission; second, to improve substantially our ability to utilize civilian health care resources to meet a larger portion of our peacetime benefit demand; and third, to accelerate the redirection of our military direct care system to effectuate our top-priority commitment to medical readiness. Meeting these challenges will likely require some departures from traditional methods of operation. If so, we will have to be ready to make such departures.

Medical readiness is, of course, our reason for being and I assure you, Mr. Chairman, that my attention and efforts in this area will not falter. It is the very least we owe to those who risk life and limb in combat, to defend this nation.

Senator WILSON. Thank you very much, Dr. Mayer.

Before hearing from the Surgeons General, we will hear from General Toner.

STATEMENT OF MAJ. GEN. FRANCIS TONER, U.S. ARMY, DEPUTY DIRECTOR FOR STRATEGIC MOBILITY, DIRECTORATE OF LOGISTICS, ORGANIZATION OF THE JOINT CHIEFS OF STAFF

General TONER. Mr. Chairman and members of the subcommittee, I am pleased to appear before you today to discuss wartime medical readiness and planning. This morning I will briefly comment on functions of the JCS, the OJCS and the service military departments.

In addition, I would like to talk briefly about wartime medical planning, its development and the theater commander's role in establishing medical host nation support.

As you are well aware, the JCS serve as advisers and military staff members in the operational chain of command with respect to the unified and specified commands. They also prepare the strategic plans and provide for the strategic direction of our Armed Forces.

Finally, they review the plans and programs of the theater commanders to determine their adequacy, feasibility and suitability for the performance of their assigned missions.

The OJCS really has the responsibility of supporting the chairman and the JCS. The military departments are key players in the readiness arena because they have the responsibilities for organizing, training and equipping forces that are placed under the command of the Unified and Specified Commanders.

In addition, they prepare and submit the budget and administer the funds that are made available for maintaining our forces in the field.

With respect to medical planning, the health of our Armed Forces is vital to the sustainability of U.S. military operations. Our ability to protect our national interests, honor our treaty commitments, and defend U.S. territories begins with operational planning.

These plans evolve from theater threat assessments and they include the commander's concept of operations and identify the requirements necessary to execute assigned missions. Medical support is an essential part of each and every operational plan.

The following general steps are involved in theater joint medical planning as it takes place today. The medical planners develop theater requirements in accordance with the Joint Operations Planning System or JOPS.

Within this system the planner uses an ADP software program called a medical planning module or MPM. The MPM is capable of providing the service components with the requirements for hospital beds, physicians, blood and medical supplies based on established scenarios and number of personnel at risk.

From established requirements the service components in each theater prepare medical support plans which are then forwarded to theater commanders for review and analysis. The theater medical staffs then evaluate the component plans to ensure the correctness of the planning factors used to develop requirements. They also compare capabilities to requirements and they ensure avoidance of duplication and use of joint facilities where feasible.

Finally, they make an addressal of all the medical shortfalls. Upon completion of the analysis and reconciliation of service shortfalls by the unified command medical staff, a medical annex is prepared and incorporated into operational plans.

The service shortfalls are identified and referred to their respective military departments for consideration during the annual Program Objective Memorandum of each department.

Turning now to our medical capability. In the late 1970's and early 1980's our ability to provide medical readiness capability was seriously limited. However, significant changes in services' medical programs for wartime support have occurred over the past several years.

Our capability today is substantially higher than it was in 1980. It has increased by 33 percent within the last year and roughly 82 percent within the last 2 years, admittedly starting from a very low baseline. This significant increase is due to the receipt of medical assets and materiel funded by the services in the last several years.

Through the 1987 to 1991 FYDP medical readiness capability will continue to improve due to the number of medical systems programmed for procurement. Requirements are scheduled to be met by 1992.

In addition to procurement, theater commanders have looked to host nation support to offset shortfalls in wartime support requirements. As executive agents for negotiating host nation support, theater commanders have been successful in consummating agreements in both Europe and the Pacific.

Currently, we have agreements that provide assets to support U.S. forces during hostilities in both EUCOM and Pacific theaters. These include hospital facilities, buildings for storage, mobilization sites for U.S. forces, land for contingency use, professional and support personnel and transportation for moving casualties within theater.

It should be pointed out that host nation support negotiations are slow, time consuming operations which yield results only after perseverance and determination.

We have seen significant improvements in our theater support in Europe and in the Pacific. Congressional support has provided service funding for storage facilities around the world, notably in Germany, United Kingdom, and Korea. These storage facilities in conjunction with host nation provision of land and other assets continue to enhance our capability to provide medical support and evacuation of U.S. forces in our overseas theaters.

In conclusion, I should say that although significant improvements have been made in our medical readiness capability, there is still very much to be done. Medical staff and support personnel must be compatible with the number of hospital systems coming into our inventory.

Our projection for hospital beds, including deployable medical systems should be realized by 1992. However, congressional support to fund these medical programs for personnel and equipment will continue to be needed. In this regard, we solicit your support.

Mr. Chairman, this concludes my statement.

[The prepared statement of General Toner is as follows:]

PREPARED STATEMENT BY MAJ. GEN. FRANCIS J. TONER, ORGANIZATION OF THE JOINT CHIEFS OF STAFF

Mr. Chairman and members of the Subcommittee, I am Maj. Gen. Francis J. Toner, Deputy Director for Strategic Mobility, Directorate of Logistics/J-4, Organization of the Joint Chiefs of Staff (OJCS). I am pleased to appear before you today to discuss Wartime Medical Readiness and Planning. We believe this is the first opportunity for a representative of OJCS to appear before a Congressional committee to discuss medical readiness.

This morning, I will briefly comment on the functions and responsibilities of the Joint Chiefs of Staff (JCS), the Organization of the Joint Chiefs of Staff (OJCS), and the military departments. In addition, I will highlight wartime medical planning, its development, and the theater commanders role in establishing medical host nation support.

OVERVIEW

The JCS serve as advisors and military staff members in the "operational" chain of command with respect to the unified and specified commands. The JCS prepares strategic plans and provides for the strategic direction of the Armed Forces. Additionally, they review plans and programs of commanders of unified and specified commands to determine adequacy, feasibility and suitability for the performance of assigned missions.

The OJCS supports the Chairman and the Joint Chiefs. Within the structure of the OJCS, there are Directorates in the areas of Personnel (J-1), Operations (J-3), Logistics (J-4), and Plans and Policy (J-5). These Directorates and their staffs support the Joint Chiefs in carrying out their functions and responsibilities.

The military departments, under their respective Secretaries, are the key players in the medical readiness arena because they:

a. Organize, train, and equip the forces for assignment to unified and specified commands.

b. Prepare and submit budgets and administer the funds made available for maintaining, equipping, and training the forces.

MEDICAL PLANNING

The health of our Armed Forces is vital to the sustainability of US military operations. Our ability to protect national interests, honor treaty committments, and defend US territories begins with the development of operational plans. These plans evolve from theater threat assessments and include the commanders concept of operations and identity of requirements necessary to execute the assigned missions. Medical support is an essential part of operational plan development. The following steps are involved in the Joint medical planning process:

a. Medical planners develop theater requirements in accordance with the Joint Operations Planning System (JOPS). Within this system, the planner uses an ADP software program called the Medical Planning Module (MPM). The MPM is capable of providing the theater Service components with requirements for hospital beds, physicians, blood, and medical supplies based on estabiished scenarios and the number of personnel at risk.

b. From established requirements, Service component commands prepare medical support plans which are forwarded to theater commanders for review and analysis.

c. Theater medical staffs evaluate component plans to insure correctness of planning factors to develop requirements, appropriate comparison of capabilities to requirements, potential avoidance of duplication and joint use of facilities where feasible and conscious addressal of shortfalls.

d. Upon completion of analysis and reconciliation of Service shortfalls by the unified command medical staff, a medical annex is prepared and incorporated into operational plans.

e. Service identified shortfalls are referred to respective military departments for consideration during annual Program Objective Memorandum (POM) development.

CAPABILITIES

In the late 70s and early 80s our ability to provide a medical readiness capability was seriously limited. However, significant changes in the Services' medical programs for wartime support has occurred over the last several years. Our capability today is approximately 90 percent higher than it was in 1980. It has increased by 33 percent within the last year and roughly 82 percent during the last two years. This significant increase is due to receipt of medical assets and materiel funded by the

Services from earlier procurement years. Through the 1987-1991 FYDP medical readiness capability will continue to improve due to the number of medical systems programmed for procurement. Requirements will be met by 1992.

HOST NATION SUPPORT

In addition to procurement, theater commanders have looked to host nation support (HNS) to offset shortfalls in wartime support requirements. As executive agents for negotiating HNS, theater commanders have been successful in consummating agreements in Europe and the Pacific. Currently, we have agreements that provide assets to support US forces during hostilities in USEUCOM and USPACOM theaters. These agreements include hospital facilities, buildings for storage, mobilization sites for US forces, land for contingency use, professional and support personnel, and transportation for moving casualties within theater. It should be pointed out, however, that HNS negotiations are slow time consuming operations which yield results only after perserverance and determination.

We have seen significant improvements in our theater support in Europe and the Pacific. Congressional support has provided Service funding for storage facilities around the world, notably in Germany, United Kingdom, and Korea. These storage facilities in conjunction with HNS provisions of land and other assets continue to enhance our capability to provide medical treatment and evacuation for US combat forces in USEUCOM and USPACOM.

CONCLUSION

Although significant improvements have been made in our medical readiness capability, there is still much to be done. Medical staff and support personnel must be compatible with the number of hospital systems coming into the inventory. Our projection for hospital beds including deployable medical systems should be realized by 1992. However, Congressional support to fund medical readiness programs and personnel increases will continue to be needed. In this regard, we solicit your assistance.

Mr. Chairman, this concludes my statement. I am ready to respond to any questions you may have.

Senator WILSON. Thank you very much, General Toner.

We will hear next from General Becker, Surgeon General of the Army.

STATEMENT OF LT. GEN. QUINN H. BECKER, U.S. ARMY, THE SURGEON GENERAL

General BECKER. Thank you, Mr. Chairman, Senator Glenn, and Senator Nunn. It is a great privilege and pleasure for me to appear here and have an opportunity to tell you my part of the story about the Army Medical Department.

I have a prepared statement which I would like to submit for the record. I would like to make a few remarks prior thereto. These remarks are not necessarily in the statement.

Our primary mission is, without a doubt, readiness for war. We fully understand that. We are very proud of our practitioners and the work they do.

I have to tell you they are a little bit demoralized at the present time, not to the point they are incapable of performing their mission, by any means, but the adverse publicity and the incidents that have appeared in the press have caused them great concern.

Certainly we all are concerned about these incidents and we will talk more about those in our peacetime hearings, I am sure.

They deserve good leadership and a good system in which to function. We are very pleased and proud of our cooperation with our sister services and I think that has improved dramatically over the past several years. We work closely together, all of us here.

Now, we maintain our readiness in the Army, and in the other services, too, I am sure, by our practice in the peacetime health care system and we keep our people skills honed for war by actual practice on patients. For them to be in a standby mode over a long period of time would be detrimental to those skills, we believe.

Our job is to provide the initial mobilization medical units early in the war. There is no other system for a very short-notice war to get rapid replacements to the front. They must come from the medical services. We understand that very clearly and we have been working very hard to achieve even shorter and shorter times where we can medically respond and return replacements to the front lines.

I am pleased, as I said, to be here and I stand ready for any questions that you might have.

Thank you very much.

[The prepared statement of General Becker follows:]

PREPARED STATEMENT BY LT. GEN. QUINN H. BECKER, THE SURGEON GENERAL, DEPARTMENT OF THE ARMY

Mr. Chairman and Members of the Committee, I am Lt. Gen. Quinn H. Becker, the Surgeon General of the Army. I am pleased to have this opportunity to appear before your subcommittee to discuss the Army Medical Department (AMEDD); its' readiness for combat and contingency operations; and our peacetime health delivery system. I acknowledge your continuing interest and assistance to the Army Medical Department in the past and request your support in promoting our future programs.

The AMEDD is aggressively pursuing our multifaceted mission of maintaining a physically and mentally fit military force; preparing itself with equipped and trained health resources for approved combat and contingency operations; and insuring a quality peacetime health delivery program for all beneficiaries as currently authorized by law. The AMEDD system simultaneously supports these missions in its' day to day operation.

I would like to thank the Congress for approving space available dental care for active duty dependents and the reduced veterinary user fee. Both of these actions indicate the continued sensitivity of the Congress to the needs of the soldier and his family.

Of great concern to me is the recent media coverage, questioning the ability of the military health care system to provide quality health care. The focus has been on a few incidents that do not reflect the totality of the quality care being provided to our beneficiary population. The perception created by these reports is totally false. We have a good system and our Army Medical Department is made up of an exceptionally fine group of dedicated and devoted professionals who are performing in a superb manner in providing service to their patients. We are a health care system that on the average admits a patient every 1.2 minutes to one of our 50 hospitals; delivers a baby every 10 minutes; has 7,200 beds occupied every day; conducts, on a daily basis, 67,000 outpatient visits in these hospitals and in over 250 clinics which serve the soldier at locations away from the hospital; gives 13,000 immunizations, performs 40,000 x-ray procedures, issues 90,000 prescriptions; and generates 720,000 laboratory tests daily. In a system as large and diverse as ours we do have accidents and untoward incidents, some with tragic results, but they are by far the exception. Military medicine is not a mess. In fact, it is exceptionally good, but not good enough.

As the Surgeon General I am demanding that we insure that every practitioner is licensed and accurately credentialed. To this end we have nearly completed a 100% audit of all health care providers. As of this date 100% of active duty physicians have had their graduation from medical or osteopathic school verified. In addition to active duty, the education of physicians in the Army National Guard, Army Reserve and civilian employees are being verified. Currently, we are over 95% complete. A further verification is ongoing with a review of the American Medical Association (AMA) profile data for licensure and disciplinary action. In addition to a physician audit, the AMEDD is auditing non-physician providers. Included in this group are dentists, nurses (civilian only), optometrists, pharmacists, physical thera-

pists, podiatrists, psychologists and veterinarians. To date, no further instances of fraudulent credentials have been discovered.

We must continue to check ourselves to insure that credentials committees act on problem practitioners. I have directed that when a serious problem occurs in one of our medical treatment facilities I am immediately notified; that a local investigation be initiated; that the provider's privileges be suspended as appropriate; and that the quality assurance personnel act promptly. Patients and family involved will be represented by one of our hospital staff members to help them get information they need about what happened and what we are going to do about the problem. All our patients and their families are treated with respect and dignity. I expect the Commander to take prompt action on providers with suspended credentials. Based on the results of the investigation the Commander can reinstate the providers privileges, require retraining, increase supervision or initiate elimination from the military.

The provision of quality health care has the highest priority within the Army and the Army Medical Department. The current environment within which civilian and military medicine is practiced mandates a hard look at the AMEDD to determine if there are systemic problems which undermine its responsiveness to the Army family. To this end, the Surgeon General's Task Force on Health Care has been established. The Task Force is an independent agent of the Surgeon General, reporting directly to me and is vested with the authority to act on my approval on matters pertaining to the Army's health care system. Actions of the Task Force which are ongoing or complete are: the follow on verification of licensure and disciplinary action with the AMA; implemented a 100% licensure screen with the Federation of State Medical Boards; strengthen the physician accession criteria; designed the mechanism for a verified central data base of all physicians for education, licensure, graduate medical education and credentials; and added a quality assurance cell in the AMEDD personnel center to fix responsibility for record keeping.

In January of this year our quality assurance regulation was updated to include more stringent pre-credentialing and credentialing policies, procedures and reporting requirements. The update also delineates new risk management procedures and reporting policies. In the next few months we will be fielding a new automated Quality of Care Evaluation Support System which includes mortality reporting, occurrence screening, emergency room screening, and provider activity profiles. In our fiscal year 1986 budget we are requesting 115 civilian authorizations to assist with the quality assurance functions in all our hospitals. This manpower, in addition to that already in place, increased command interest and fixed responsibility throughout the chain of command, will enable the Army medical system to improve the quality of care that we already provide and is deserved by our beneficiaries.

While the AMEDD has a tremendous peacetime health care responsibility, the AMEDD is not considered just a peacetime health care delivery force. We, like the rest of the Army, must be prepared to go to war at anytime. With this peacetime force, we must be capable of making a smooth transition to a wartime posture. If deterrence fails, we must be able to provide medical support in a combat environment with little or no advance notice. Medical readiness has been the subject of recent reports which question the ability of the military to provide adequate health care to U.S. servicemembers in combat. These reports have painted a rather bleak picture of the current capabilities of the services. Though there is much to be done, the reports do not address the actual and programmed improvements which have taken place over the past five years.

During the early 1980s a number of actions occurred. As an interim measure, the Army reintroduced the Mobile Army Surgical Hospital to alleviate severe shortfalls in surgical care in forward areas. A medical planning cell was established in the United Kingdom to survey contingency hospital sites and receive equipment sets for five General Hospitals in support of NATO. Two General Hospital sets were forward deployed in Sagami, Japan in support of Northeast Asia. Similar efforts have taken place in Southwest Asia. Renewed emphasis was placed on securing host nation support agreements in all theaters for critical health care delivery services during hostilities. Fully equipping all deployable medical units in both the active and reserve components became a major programming objective of the Army. Finally, the standardization effort of the quad-services, developed the Deployable Medical Systems which provide identical major components for the four services field hospital units.

Planning for operations is conducted using the Joint Operations Planning System. Medical planners determine requirements using the Medical Planning Module (MPM). This is a subsystem of the Joint Operations Planning System. The MPM is designed to be compatible with the organization and structure of each of the services and to recognize the unique requirements of each service.

The Medical Planning Module derives a Population at Risk (PAR) which is subdivided both by geographic operation zones and unit type. The population at risk serves as the source of daily admissions to the medical system computer by operations zone arrayed into patient classes whose number, length of stay, and death rate are determined by service developed data. Admissions are, in turn, used to compute patient load, evacuations, bed requirements, returns to duty and other medical requirements (blood, supplies, etc.). Once the MPM data is generated the medical planner develops the type and number of medical units needed to support the plan. The Army generally plans for 1-Mobile Army Surgical Hospital, 1-Combat Support Hospital, and 2-Evacuation Hospitals (1,060 total beds) per each division supported. This is a gross planning factor and may be modified depending on the operations.

The Army computes wartime medical requirements through the Total Army Analysis (TAA) process. In this process a warfight computer simulation of the Defense Guidance Scenario is performed to determine the total theater force structure requirement. This structure requirement is extrapolated into a manpower requirement through the use of Tables of Organization and Equipment (TOE's) which specify the number and type of personnel in each Army unit. The TOE is prepared by the medical combat developer using Army methodology and is processed through the Army Training and Doctrine Command system before receiving Department of the Army approval. All TOE's are reviewed at specific intervals to ensure that they remain valid requirement documents. The Continental United States manpower requirements are determined through a workload based process and are published in Tables of Distribution and Allowances (TDA's), which are prepared and reviewed much like the TOE's. Mobilization TDA requirements depend significantly on the workload transferred to the Continental United States from the theaters. A new methodology for determining manpower requirements for both theater and the Continental United States is being used in the Army Program Objective Memorandum for fiscal year 1988-92. The Army, like the Navy and Air Force, is using the Joint Operational Planning Systems Medical Planning Module to determine both requirements.

In 1984, the Army expanded its procurement program to fully equip 163 combat hospital units with 72,000 beds by 1991. Thirteen hospital equipment sets were purchased in 1984 for delivery in 1986-87. An additional 25 hospital sets are being purchased in fiscal year 1985 for delivery in 1987-88. The fiscal year 1986 budget request includes funding to purchase 24 more sets. Funding is also included for the modernization of division level medical units. The funding stream over several years reflects a reasonable economic level of acquisition that can be properly executed. Beginning with the fiscal year 1986 purchase, lag time for delivery will be two years rather than three years for the purchases in fiscal year 1984 and fiscal year 1985. By fiscal year 1993, all hospitals will be equipped with the Deployable Medical Systems (DMS) generation of field hospital equipment.

Growth in health provider assets has been substantial over the last 5 years. U.S. Army Reserve Troop Program units have grown from 925 physicians in fiscal year 1980 to 2,325 in fiscal year 1985; the Individual Ready Reserve from 766 in fiscal year 1980 to 1,762 in fiscal year 1985. The National Guard has gone from 417 to 812 physicians. Nurses and other specialists have experienced similar growth. Physician and nurse recruiting for the reserve components has been enhanced through flexibility in training and service options for the medical professional while retaining a commitment in the event of mobilization. However, personnel shortfalls still exist, especially in surgical specialties, operating room nurses, and some enlisted specialties.

The Army has sufficient aggregate personnel strength to man about 82 percent of its' medical units upon mobilization. The growth realized in personnel assets since 1980 is expected to slow as recruiting concentrates now in the "hard" surgical specialties skills which are more difficult to attract. Without considering the impact of training readiness or skill qualification, sufficient personnel resources can be made available to meet battlefield health care needs of the theater, even as the enhancements in medical equipment readiness come to fruition through 1991. However, when medical personnel resources are fully allocated to the combat theater, it should be clearly understood that the Army medical support remaining in the Continental United States would be severely limited. This is attributable to personnel shortages in the remaining Continental United States base system, particularly the Individual Ready Reserve. Therefore, health care for returning casualties would rely heavily on the Veterans Administration and the National Disaster Medical System.

Since current programs will not fill existing manpower gaps, new initiatives are being researched to identify programs that will bring Reserve Component medical personnel assets to the required levels by 1992. Until such time as new programs

are initiated, an alternative solution is the peacetime registration of health professionals. This appears to be the only means of meeting near term mobilization requirements given existing shortfalls in the critical skills.

Wartime training programs have been implemented throughout Army Reserve and Army National Guard medical units that are in compliance with requirements of two new DOD wartime training programs. All units are aware of their wartime alignment. All units have met or are in communication with their wartime headquarters and have received mission guidance, deployment information, and training priorities. Most units have participated in either command post exercises or field training exercises with one or more of the units that they will be associated with in wartime. More importantly, all units have plans for such exercises over the next 2 years. Early deploying Reserve and Guard units are scheduled on a three to five year cycle for overseas duty training. Also, most headquarters units have sent unit representatives to participate in command post exercises with their wartime active components overseas. Currently, there is a system established for the peacetime chain of command to monitor wartime training and to coordinate exercises.

To further enhance readiness, active and reserve component medical personnel have been active participants in the Security Assistance Program and the AMEDD can point proudly to recent readiness accomplishments; Mobile Medical Training Teams (MTT) in El Salvador; medical support to the Regional Military Training Center in Honduras; and support of large scale training exercises in Honduras. The MTT has trained 884 combat medics, 19 senior medical NCO's, 39 medevac aidmen, 15 dental technicians, 58 intensive care nurses, and 9 biomedical technicians. In addition, they have improved the medical supply system, provided field sanitation guidance, assisted in the completion of the military hospital, provided combat surgery instruction, initiated a medical civic action program, participated in structuring a unified military medical system and created a 72 man Medical Service Corps. The great need of our Central American allies for medical training and humanitarian medical support, as well as our requirement to support training of U.S. forces, will dictate our continued AMEDD support.

An adjunct to readiness is the training of AMEDD personnel. Graduate Medical Education of our physicians ensures that there are trained physicians available to treat the medical needs of our patients. This means that infants are delivered by obstetricians and fractures are set by orthopedists. The largest source of physicians entering the Army are from the Health Professions Scholarship Program (HPSP) and the Uniformed Services University of the Health Sciences (USUHS). These physicians are not specialty trained when they enter active duty. While they are completing training they are at the same time delivering care to DOD beneficiaries. Other AMEDD personnel are trained in the Warrant Officer Entry Course, Battalion/Brigade Pre-Command Course, AMEDD Officer Advanced Course, Combat Casualty Care Course, "All Corps" Basic Officer Course, and new and revised enlisted training courses.

The AMEDD's research arm, the Medical Research and Development Command, has produced some significant accomplishments, such as the development of chemical warfare agent decontamination resins against mustard and nerve agents. Equally impressive is a micro-encapsulated antibiotic for slow release developed to control maxillofacial wound infection. The U.S. Army Institute of Dental Research, is perfecting its synthetic biodgradable, biocompatible material that will replace and repair bone loss due to trauma. Research continues in the development of a vaccine that will provide protection against dysentery. In the equipment area we are continuing to develop a field oxygen generating system, field radiographic and flouroscopic system, resuscitation devices for field use and a resucitative fluids production system which uses potable water to produce surgical and intravenous fluids that meet FDA safety standards.

While the AMEDD is fully committed to improving its medical readiness and peacetime health care, it is also actively pursuing numerous cost containment initiatives. However, to simultaneously pursue medical readiness, improve peacetime health care, and implement cost containment, requires significant tradeoffs, particularly in terms of productivity. For instance, AMEDD programs in support of readiness, such as the over 40 years of age Cardiovascular Screening Program, physical fitness, field training and the Exceptional Family Member Program are costly to the direct care system as resources are diverted from direct care to support readiness. Also, extensive quality assurance efforts are similarly expensive and reduce resources available for direct health care delivery. Therefore, in assessing the AMEDD's commitment to these programs, it is obvious that true productivity cannot be measured exclusively in the peacetime mode. There is a balance that must be maintained between peacetime health care delivery, readiness, and cost

containment which meets the needs of the Army and yet adequately reflects true productivity and the proper utilization of resources. The thrust of cost containment in the Army is the reduction of system costs within DOD by reducing CHAMPUS usage and increasing utilization of the direct care system. Many initiatives have been developed in an effort to reduce health care expenditures without reducing quality and accessibility. These include emphasis on personal services contracts, catchment area demonstration projects and CHAMPUS cost containment initiatives.

The fiscal year 1984 Defense Authorization Bill included a change which raised the statutory compensation limits and authorized the use of personal services contracts for direct health care personnel. Military physician manning levels have improved over the years due in large part to the Health Professions Scholarship Program, the Uniformed Services University of Health Sciences, and improved compensation for military physicians. However, in spite of these gains, some specialties are still in short supply. Personal services contracts will allow the services to fill physician and other health professional shortfalls through contractual arrangements. These contractual arrangements may be less costly than the alternative, which is the CHAMPUS program. An AMEDD policy is being developed that will ensure the efficient use of resources by maximizing the ability of hospital commanders to use the various available supplemental resource tools, i.e., VA/DOD Health Resource Sharing Program, Joint Health Benefits Delivery Program, and Personal Services Contracting.

The fiscal year 1984 Authorization Act gave the Secretary of Defense authority "to conduct studies and demonstration projects on the health care delivery systems of the uniformed services with a view to improving the quality, efficiency, convenience, and cost effectiveness of providing health care services." The Assistant Secretary of Defense for Health Affairs requested the Army to undertake a demonstration project which would combine the dollar requirements for care provided under the CHAMPUS program with the resources of the direct health care system for a particular catchment area. These resources would be placed under the exclusive control of the medical treatment facility (MTF) commander. The MTF commander would be responsible for providing all health care required by authorized beneficiaries who reside within the catchment area. A catchment area is an identifiable geographic area with a radius of approximately 40 miles. The 40 mile radius was selected to be compatible with the law which defines the CHAMPUS non-availability statement requirement for inpatient care. The site selection criteria was completed on February 1, 1985, and the MTF, Fort Ord, California, was the selected site. During September 1985, an extensive internal publicity campaign is being conducted and the project is to be fully operational by October 1, 1985.

The Office of the Surgeon General proposed and the Army leadership has approved the Satellite Care Clinic concept. Implementation of the Satellite Care Clinic concept is a highly visible effort to reduce utilization of the CHAMPUS program and to expand the AMEDD workbase thru contracting. Under this concept, services would be provided in the community where the beneficiary population resides. This model is ideally suited to test new primary care delivery concepts in the area of patient education, patient flow, medical records, and appointment systems. The first test clinic is scheduled to become operational October 1, 1985, in the Fort Belvoir, Virginia catchment area. If successful, 10 additional clinics are scheduled to be opened between fiscal year 1987-91, giving the AMEDD 11 Satellite Care Clinics. These clinics are to be located in areas of large troop concentrations with significant numbers living off the installation (Fort Bragg, Fort Benning, Fort Hood).

Another Army initiated deomonstration project is under development at the MTF's at Fort Campbell and Fort Knox, Kentucky. The demonstration project proposes staffing these hospitals at fully required levels rather than minimally required as is normal. The intent is to measure the effects on workload, patient and provider satisfaction, quality of care and the cost benefit associated with increased staffing.

To achieve the goal of an Army free of the effects of drug abuse, the AMEDD supports combat readiness and the Army Drug and Alcohol Program by operating three urinalysis drug testing laboratories. Over the past two years, the Army urinalysis drug testing program has undergone major improvements. In January 1984, the Army began adopting a series of recommendations from a panel of legal and toxicological experts to improve the operation and forensic credibility of the drug testing program. The drug testing budget estimate for fiscal year 1986 was reduced $3.0 million. This was due, in part, because a portion of the resources required to adopt the panel recommendations were one time costs. The remainder of the decrement resulted from an assessment that the program is effectively deterring drug abuse and therefore could be scaled back. This reduction will reduce overall drug testing by

approximatley 9 percent. With some decentralization of initial screening at the installation level, and confirmation testing performed at the laboratories or under contract, drug testing will continue to be a major deterrent to drug use.

Since 1977, the Army Medical Department has continued to expand its residential treatment facilities for alcohol abuse. Currently there are 9 Army and 2 Tri-Service facilities located throughout the world. Bed capacity has increased from 100 to 300 since 1977 and approximately 1,500 patients a year are treated. Almost all patients are under treatment for alcoholism, as inpatient treatment for drug abuse is increasingly uncommon. In December 1984, the decision was made that the Director of Health Services at the installation level would be responsible for quality assurance for all aspects of alcohol and drug treatment whether performed by hospitals or Community Counseling Centers which are outside the direct control of the medical facility commander. Hospital clinical consultants to the outpatient portions of the program will be the bridge between AMEDD and communities, and medical quality assurance will be applied to the entire Alcohol and Drug Abuse Program.

In conclusion, the Army Medical Department is dedicated to providing the medical care required in combat and peacetime. We are working diligently to put the mechanisms in place that will ensure we provide quality health care. The progress we have made and are continuing to make should not be overshadowed by a few isolated claims of poor medicine. The key to this system is the 72,000 dedicated officers, enlisted soldiers and civilian professionals who provide concerned care to the Army. I personally am committed to working with the Congress to see that our mutual goals are attained and that soldiers and their family receive the type of medical care they deserve.

Mr. Chairman, that concludes my prepared statement. I will be happy to answer any of your questions.

Senator WILSON. Thank you very much, General Becker.

We will now hear from Admiral Seaton, Surgeon General of the Navy.

STATEMENT OF VICE ADM. L.H. SEATON, U.S. NAVY, THE SURGEON GENERAL

Admiral SEATON. Good morning, Mr. Chairman and members of the subcommittee.

I thank you for the opportunity to appear before you today to discuss wartime requirements for the Navy Medical Department.

At the risk of being redundant, the Navy Medical Department's No. 1 priority is to deliver the best possible medical care to Navy and Marine Corps operating forces in time of war. To accomplish this, we must provide responsive medical capability to support the fleet and a flexible, highly mobile medical unit to support the combat mission of the Fleet Marine Force.

Our mission in the combat theater is to return Navy and Marine Corps patients to duty as quickly as possible. If they cannot be returned to their combat units immediately, our mission is to stabilize and evacuate patients. By placing sufficient medical care as close to combat areas as possible and returning personnel to duty, the Navy medical department contributes directly to the sustainability of combat operations.

In accordance with Defense guidance, the requirement for manpower, equipment, and supplies is based on the number of casualties expected in the theater of combat. Our current capabilities to meet wartime medical requirements include medical elements with ships and squadrons and the Fleet Marine Force, casualty receiving and treatment ships, a 1,000-bed rapidly deployable medical facility and Navy hospitals overseas and here in the continental United States.

In the planning and programming arena the outyears contain identified shortfalls in meeting defined requirements for in-theater casualty care which are programmed to be met by the hospital ship program and fleet hospital program.

The hospital ship program will provide two afloat, surgically intensive, acute care hospitals with 24 operating rooms and 2,000 beds. Both ships, USNS *Mercy* and USNS *Comfort* will be delivered in fiscal year 1987. Once operational, these ships will be maintained in reduced operating status ready to deploy in 8 days. They will support the Navy and Marine Corps combat operations.

The fleet hospital program will deliver definitive health care to the troops through the use of geographically prepositioned facilities to be placed in the combat and communications zones of operation. Once completed, this program will provide over 13,000 contingency hospital beds.

The Navy's hospital system remains the cornerstone of our medical readiness. In time of war, overseas hospitals can act quickly to reach their expanded contingency capability to support operations in their area. While our hospital system in the United States serves as a source for trained personnel for immediate deployment, our Navy Reserve medical personnel will both staff deployable hospitals and augment continental U.S. medical facilities by filling vacancies created by the deploying active duty medical forces. Reserves will continue to expand our CONUS facilities to their maximum bed capacity.

New initiatives in the area of operation and mobilization planning have achieved substantial progress. We are establishing a career pathway in medical readiness planning for selected medical department officers.

Over the last several years we have concentrated on achieving the right number and mix of medical personnel. For the third straight year, we met our authorized physician endstrength. The Armed Forces Health Professions Scholarship Program established by Congress supplies more than 80 percent of our physicians and has been the most effective initiative in achieving this goal. While problems still remain with physician specialty mix, we have programs designed to correct specialty shortfalls over the next few years.

I am confident we have developed comprehensive plans and programs that will meet our wartime objectives in the years ahead. Your support of our program is crucial to our ability to provide adequate combat medical care.

That concludes my statement. I will be pleased to answer any questions.

[The prepared statement of Admiral Seaton follows:]

PREPARED STATEMENT OF VICE ADM. LEWIS H. SEATON, MEDICAL CORPS, U.S. NAVY, DIRECTOR, NAVAL MEDICINE AND SURGEON GENERAL, DEPARTMENT OF THE NAVY

Mr. Chairman and members of the subcommittee: I am Vice Admiral Lewis H. Seaton, Medical Corps, United States Navy, Director, Naval Medicine and Surgeon General of the Navy. I welcome this opportunity to appear before you today to discuss the ability of the Navy Medical Department to support Navy and Marine Corps contingency operations.

The number one priority of the Navy Medical Department is to deliver the best possible care to Navy and Marine Corps operating forces in time of war. To accom-

plish this, we must provide a rapidly responsive medical capability to support the Fleet and a flexible, highly mobile medical force to support the operational combat mission of the Fleet Marine Forces (FMF). Our mission requires that we provide a continuum of combat casualty care that reaches from the front line hospital corpsman at the forward edge of the battle area to stateside health care facilities. This continuum contains multiple levels of care with increasing capabilities as a casualty moves to the rear. The most forward elements of the medical support system are highly mobile and are designed to treat combat casualties, and to either stabilize them for evacuation or to return them to duty as soon as possible. Medical support assets located farthest from the combat zone are less mobile and have a greater capacity to provide definitive care for wounded or seriously ill personnel. We have tailored our deployable medical systems to be consistent with the levels of care required at all points along the continuum.

To support a major war, anywhere in the world, the Navy Medical Department must be prepared to provide and support a medical system in the combat theater that is capable of providing care to a large number of casualties. For contingency operations less than a major war, the medical department must provide a scaled down combat care capability appropriately sized to meet the threat. In either case, the Navy medical system must possess:

(1) Mobility to deploy with the Fleet and FMF;

(2) Flexibility to tailor medical capabilities to mission requirements; and

(3) Responsiveness to provide medical care when and where it is needed.

The mission of the Navy Medical Department in the combat theater is to return patients to duty with the FMF and the Fleet when possible, and to stabilize and prepare for evacuation those patients who cannot be treated in-theater. By placing adequate medical services as far forward in the continuum of care as possible and by returning trained, combat experienced personnel to duty, the medical department contributes directly to the sustainability of combat operations.

WARTIME MEDICAL CARE PLANNING

Wartime medical care requirements are determined by the missions of the Fleet and FMF. They vary from requirements for several thousand beds in support of a major war to requirements for little more than the organic capability needed to support a limited contingency. The best location for medical facilities is similarly determined by the missions of the operating forces.

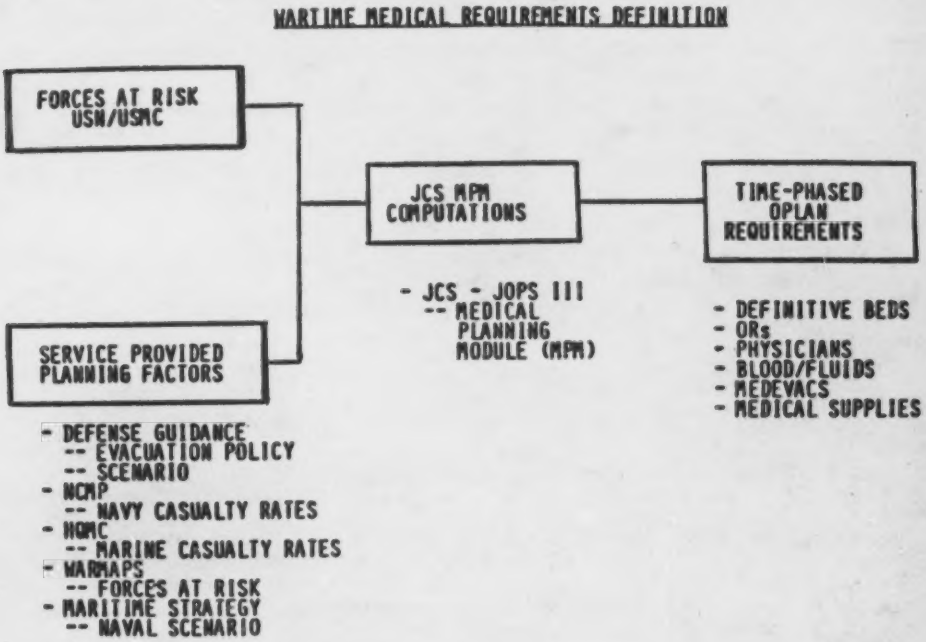

FIGURE 1

As displayed in Figure 1, the methodology for determining bed requirements to support the operating forces is a structured, rigorous process. Medical wartime planning factors are provided from a number of significant sources, including the Defense Guidance (DG) which specifies a global scenario and evacuation policies; the Department of Defense (DOD) Wartime Manpower Planning System (WARMAPS) which provides the estimated population at risk and casualty estimates; the Navy Capabilities and Mobilization Plan (NCMP) which provides estimates of casualty rates; casualty estimates from Headquarters, U.S. Marine Corps; and the Maritime Strategy which provides the naval strategy for the DG global scenario.

Total requirements, including personnel and requirements for medical facilities for each theater, are developed using the Medical Planning Module (MPM) of the Joint Chiefs of Staff Joint Operations Planning System (JOPS) III. Data from the MPM are then used to determine medical support requirements and to identify shortfalls. Resupply estimates are used to schedule time-phased lift of medical materials from the United States to the theater of operations. The MPM also provides an objective method to compare medical requirements, based on in-theater casualty rates, with existing medical capabilities in order to identify shortfalls in beds, physicians, and supplies. The impact of these shortfalls is then evaluated and additional capabilities are programmed for through the DOD planning, programming and budgeting system.

Our progress in improving our operational and mobilization planning methodology has been substantial. Navy medical department staff assigned to the Organization of the Joint Chiefs of Staff (JCS) ensure that medical requirements are identified and that actual medical capabilities are an integral part of joint operational planning.

We have begun to establish a career pathway in medical readiness planning. In fiscal year 1984, we instituted courses in medical planning and medical casualty regulating at the Naval School of Health Sciences. We now have three Medical Department officers attending the Naval War College, one in the Warfare Course and two in the Command and Staff Course. Medical officers have been assigned to the Sixth and Seventh Fleets in order to ensure adequate fleet medical planning. Medical mobilization planners are assigned to our geographic commands and medical contingency planning billets have been established at seventeen naval hospitals.

To further enhance the planning capability for forces afloat, the Navy Afloat Manpower Casualty (NAMCA) Model is now completed and available for use. This past summer, the NAMCA Model was used in the Global War Games "90" conducted at the Naval War College.

MEDICAL WARTIME REQUIREMENTS AND CAPABILITIES

Current programming for wartime medical requirements is based on the number of definitive care beds needed to treat combat casualties. The data were prepared using the MPM which computes medical requirements from projected casualties and forces at risk in accordance with the fiscal year 1987 Defense Guidance.

The Navy's current capabilities to meet wartime medical requirements include organic medical elements of the FMF, Casualty Receiving and Treatment Ships (CRTS), Mobile Medical Augmentation Readiness Teams (MMART), a 960-bed contingency hospital in the United Kingdom, a 1,000-bed Rapidly Deployable Medical Facility (RDMF), and 14,340 definitive care beds contained in the expanded bed capacity of our fixed medical treatment facilities located overseas and in the United States.

The concepts for providing medical support can be best understood by reviewing the sequence of events that would take place in a wartime situation. In a contingency operation involving the FMF, the casualty's treatment begins at the forward edge of the battle area. Patients are first seen by a hospital corpsman in the field who is equipped to provide predominantly emergency and resuscitative care. His primary function is to save lives by providing advanced first aid and to assist in rearward evacuation. Injured personnel who require further care are evacuated to the next echelon of care, the battalion aid station which provides temporary shelter, emergency treatment, and stabilization. The next echelon of combat medical care is the medical battalion which provides for collection of casualties, temporary hospitalization, initial wound surgery, casualty evacuation, and preventive medicine measures for control of disease. These units are required to remain mobile and close to the battle so patients are evacuated quickly both to maintain their inherent mobility and to ensure the availability of beds and operating rooms for follow-on casualties.

Amphibious assault ships (LHA, LPH, and the planned LHD) are designed to have secondary roles as Casualty Receiving and Treatment Ships (CRTSs) after troops are

disembarked. CRTSs provide emergency, resuscitation, stabilization, and surgical care similar to the capability of the organic medical unit of the FMF. The primary mission of this class of amphibious ship is to transport Marine forces. To perform the secondary mission as a CRTS, each ship must be augmented with sufficient numbers of personnel, equipment, and supplies. Medical supply blocks are stored on these ships and provide additional operating room and intensive care nursing capability. Medical support is limited to emergency care. As with the FMF units, CRTSs are not designed to provide definitive medical support of the kind that will be available on hospital ships or in fleet hospitals. Currently there are 12 designated CRTSs.

The mission of a Mobile Medical Augmentation Readiness Team (MMART) is to serve as a unit of trained medical department personnel functionally organized and capable of rapidly augmenting the operating forces for limited, short-term (less than 180 days) military operations, disaster relief missions, and fleet exercises. These teams are composed of active duty physicians, dentists, nurses, medical service corps officers, and hospital corpsmen representing various specialty categories. The nucleus of the MMART program is the surgical team. Since their inception, MMART teams have actively participated in operational assignments including of late, Beirut, Grenada, and other forward deployed missions. MMART teams are assigned to CRTSs during exercises and scheduled deployments. These teams are kept on a rotating hour alert at their parent commands and all are fully capable and ready to deploy worldwide on short notice.

We also rely on the Rapidly Deployable Medical Facility (RDMF) to provide medical support to our operating forces in a contingency situation. The 1,000-bed RDMF which is onboard the prepositioned S.S. *Letitia Lykes* remains on station in the Indian Ocean at Diego Garcia. It is composed of four 250-bed modular combat hospitals, each containing six operating tables, and provides a rapidly deployable capability that can be off-loaded and ready to treat casualties in a matter of days with staff personnel who are pre-assigned and trained. A fire aboard the S.S. *Letitia Lykes* on 8 May 1985 destroyed approximately 25 percent of the RDMF capability. Rebuilding of the RDMF which began in June 1985 has restored 85 percent of its capability. The remaining capability will be rebuilt as soon as replacement parts have been procured.

The Navy's system of fixed medical treatment facilities is one of the cornerstones of our medical readiness capability. The hospital system in the Continental United States (CONUS) serves as the primary source of trained medical personnel for immediate deployment in wartime and as the most highly capable element in the continuum of combat casualty care. Deployment of a large number of active duty personnel from CONUS medical and dental activities will bring units of the Fleet and FMF to their wartime medical manning levels prior to their departure to the combat area. For rapid expansion to support the theater of operations in wartime, overseas hospitals will receive augmentation of their personnel. Additional active duty medical personnel will be utilized to activate the RDMF. During mobilization, CONUS facilities will be reduced to minimum staffing until reserve medical personnel are mobilized and in place.

A unit augmentation system has been developed to identify, prior to mobilization, the individuals who will fill the augmentation billets for the Fleet and FMF, CRTSs, RDMF, and overseas medical treatment facilities. Future requirements including the fleet hospitals and hospital ships will be added to the system as they come on line.

Since wartime requirements will rapidly exceed the capacity of our hospitals, we count on the Veteran's Administration (VA) and civilian facilities to supplement our capability. In the event of war or national emergency, VA medical facilities will serve as the primary health care backup to DOD to care for returning casualties. Additionally, the Civilian Military Contingency Hospital System (CMCHS) will provide a system of military casualty care in the United States involving the use of civilian hospitals. Under agreements with DOD, CONUS civilian hospitals commit staffed hospital beds in time of war to care for returning casualties. CMCHS is intended for use only in the event that military casualties generated in a conventional war abroad exceed the capability of DOD and VA facilities to care for them. We continue to work closely with the Office of the Secretary of Defense and the Department of Health and Human Services on the conversion from CMCHS to the National Disaster Medical System (NDMS), and expect that many facilities which participated in CMCHS will continue to support the NDMS program. Navy has established selected reserve teams in fourteen cities to coordinate with participating civilian hospitals.

The future ability of Navy medicine to meet the need for medical support in-theater rests on the fleet hospital and hospital ship programs. The fleet hospital program is designed to deliver definitive health care through the use of prepositioned, rapidly responsive, relocatable facilities located in combat and communications zones of operation.

The combat zone fleet hospital will be used as a surgically-intensive, full spectrum medical facility to augment the organic medical elements of the FMF, to support fleet operations, and to hold patients briefly before their return to duty or evacuation to the communications zone. To fill this role the combat zone fleet hospital is modular, transportable, capable of supporting a heavy surgical workload, and can be ready to receive casualties within a matter of days. These hospitals are designed in both 250- and 500-bed configurations.

The communications zone fleet hospital (those facilities located in the rear of the theater of operations) will care for casualties requiring follow-up definitive care. Their capabilities will include subspecialty treatment to restore casualties for return to in-theater duty or for evacuation to CONUS facilities. These facilities are designed as a 500-bed self-contained deployable hospital and a 1,000-bed pre-sited fixed facility using buildings of Host Nation Support and can be fully operational in 15 to 30 days.

Over 13,000 contingency fleet hospital beds are in procurement, budgeted in fiscal year 1986, or programmed in the Five Year Defense Plan. Fleet hospital procurement began in fiscal year 1983 with the first hospitals now scheduled for delivery in fiscal year 1987. Funds appropriated through fiscal year 1985 will allow for the procurement of a total of 4,750 fleet hospital beds. The fiscal year 1986 budget request includes funds to procure one 500-bed communication zone fleet hospital.

The hospital ship program will provide two afloat, surgically-intensive, acute care hospitals with bed capability ranging from intensive care to moderate, light, and even self-care. These capabilities, in combination with the inherent mobility of the ships and the flexibility in levels of care, will provide a valuable asset during combat operations. The program will provide a total of 24 operating rooms and 2,000 beds. Both ships, USNS MERCY (T-AH 19) and USNS COMFORT (T-AH 20), will be delivered to the Navy in fiscal year 1987. Once operational, these ships will be maintained in reduced operating status ready to deploy in eight days. They will provide a highly mobile capability to respond rapidly to support Fleet and FMF combat operations.

MEDICAL MANPOWER REQUIREMENTS AND CAPABILITIES

The size of the medical manpower force is based on wartime requirements. The JCS directed JOPS III MPM provides a set of requirements that quantify a number of key elements for wartime medical support planning. The principal output model that we use is the number of beds by theater. Programmed capabilities and their supported beds drive the manpower requirement. Our wartime manning requirements include the following activities: Augmentation of the Fleet and FMF; support of medical missions onboard CRTSs; manning hospital ships, fleet hospitals, the RDMF, and in-theater hospitals; providing support to CONUS hospitals and clinic operations.

To accomplish these functions, active duty personnel, the reserves, and retired personnel who would be recalled will be used. The active duty manpower to support these wartime missions reside in the health care system we operate today.

Our efforts to achieve the right number and mix of personnel are paying off. For the third straight year, we met our authorized physician end strength. The Armed Forces Health Professions Scholarship Program established by the Congress supplies more than 80 percent of our physicians and has been the most effective initiative in achieving this goal. While problems still remain with physician specialty mix, we have programs designed to correct specialty shortfalls over the next few years. In the past two years, recruiting goals for physicians have been targeted toward critical and undermanned specialties such as anesthesiology, orthopedics, and surgery. Maximizing the number of positions in Navy residency programs, sponsorship of people in civilian training, and judicious use of active duty deferrals for our scholarship students are initiatives we have undertaken that are focused on the critical specialties. We are starting to see the desired positive effect of these initiatives on correcting our specialty mix problem.

LIMITING FACTORS

Our deployable medical systems—fleet hospitals and hospital ships—will require a significant amount of support manpower. We have requested sufficient numbers of

personnel to staff our requirements. Your support of our manpower requirements for crucial medical readiness programs is essential to maintaining a healthy trained fighting force.

Although the hospital ship program is progressing on schedule, we have experienced contracting delays for the fleet hospital program. An 11-month delay in the delivery schedule resulted from litigation filed in Federal District Court concerning the award of the assembly and warehousing contract for the program. A new contract was awarded on 6 September 1985 and delivery of the first four fleet hospitals is now scheduled for fiscal year 1987.

The fleet hospital program rests on a requirement for rapid, mobile response to a contingency situation. In order to do this most effectively, we are pursuing host nation support agreements to establish sites in several theater locations where the hospital units can be prepositioned for movement toward the combat area or for permanent siting in the rear of the theater.

If prepositioning of fleet hospitals is not accomplished, then movement of these units from CONUS would have to compete for scarce sea- and air-lift capabilities and may restrict the availability of fleet hospitals. The prepositioning of the fleet hospitals is critical to our ability to provide adequate definitive combat casualty care.

SUMMARY

In summary, I am confident we have developed programs to meet our wartime objectives. We have produced a comprehensive strategy encompassing both manpower and deployable medical facilities to address our contingency posture in the years ahead. Your support of our programs is crucial to our medical readiness capability.

That concludes my formal statement. I would be pleased to answer any questions you may have.

Senator WILSON. Thank you very much, Admiral.

General CHESNEY. May we now hear your testimony.

STATEMENT OF LT. GEN. MURPHY A. CHESNEY, U.S. AIR FORCE, THE SURGEON GENERAL

General CHESNEY. Thank you, Mr. Chairman.

I would also like to submit my statement for the record as did General Becker and make a few short comments.

Ten years ago the Air Force was secure in feeling that we had the medical capability to take care of our Air Force personnel in wartime. Our bases were far back, were considered secure, and we thought we had a fighter force to protect them.

In the late seventies intelligence estimates showed that was no longer true. In a short period of time our number of expected casualties jumped more than 10 times. In 1980, we estimated we could only care for 1 out of 10 casualties on Air Force bases in a war.

Since that time we have, with the support of the Department of Defense and the Congress, made tremendous progress in improving our capabilities. Our number of beds available for care has doubled each year. Today, we estimate that we could care for 43 percent of our casualties and we have on order the supplies and equipment, and so forth, that would bring that to 62 percent as soon as these are delivered.

This, along with some host nation agreements that have recently been signed, gives us great confidence that within a short period of time we will almost be where we want to be. This is certainly the case for the 1990 timeframe, 5 years from now.

We have made much progress with your support and we thank you for that.

That concludes my remarks, sir.

[The prepared statement of General Chesney follows:]

PREPARED STATEMENT BY LT. GEN. MURPHY A. CHESNEY, THE SURGEON GENERAL, U.S. AIR FORCE

Mr. Chairman and members of the committee I am Lt. Gen. Murphy A. Chesney, the Surgeon General of the United States Air Force. It is a pleasure to appear before you today to give you an overview of our activities and to speak of the capabilities, plans, and programs for Air Force Medical Service wartime operations.

During peacetime, in support of the Air Force mission, we operate a three-tier hospital system—the clinic or base (community) hospital, the regional hospital, and the medical center, with the medical center offering the most sophisticated care. We consider the aeromedical evacuation mission an integral part of our health care system. Both Guard and Reserve personnelare active participants in our health care system. Within this framework, we now operate 6 medical centers, 77 hospitals, 41 clinics, and 73 aid stations around the world with a total of 5,865 beds. Thirty-six (36) of our hospitals in the United States are designated as casualty receiving hospitals in wartime and all of our medical facilities have wartime missions.

Our fixed facilities represent training and operational capabilities and are rapidly deployable resources. Since the most likely scenario for combat calls for the Air Force Medical Service to "come as we are", these facilities and their staffs form a significant part of our mobilization forces.

Let me give you two examples of continental United States (CONUS) hospitals with critical military missions—a small hospital and a large hospital: USAF Hospital Shaw, Shaw AFB, South Carolina, which is a Tactical Air Command facility, and Wilford Hall USAF Medical Center, Lackland AFB, Texas, which is an Air Force Systems Command facility.

Shaw is a 45-bed hospital. It has 23 physicians, with a total staff of 352. In Air Force hospitals, all the services such as medicine, nursing, bioenvironmental engineering, dental, aerospace medicine, etc., are generally under one roof, not scattered throughout the community and accountable to various sources as in the civilian world.

The hospital at Shaw supports the 9th Air Force Headquarters, the 363rd Tactical Fighter Wing and the 507th Tactical Air Reconnaissance Wing. The pilots and crew fly the F-16s, F-4s, and A-10s. In a wartime scenario, Shaw converts to a 90-bed acute care facility with at least three operating rooms. It will also establish a 500-bed minimal recuperative care center, a blood donor center, and a second echelon decontamination team. Furthermore, during military exercises as well as wartime, 4 of the 23 physicians would deploy with the flying squadrons for which they serve as flight surgeons. Four other physicians and one dentist would deploy with the 363rd Tactical Hospital (an air transportable hospital (ATH)), along with 42 other staff members. Two physicians and support staff would deploy with the two air transportable clinics (ATC) along with the squadrons which they support. Other staff have primary and secondary mobility missions. The air transportable hospitals and clinics are exercised periodically during the year.

Wilford Hall is a 1,000-bed facility with 450 physicians and a total staff of approximately 4,000. In a global war, its personnel staff a 500-bed fourth echelon hospital (RAF Little Rissington, United Kingdom), a 250-bed deployable hospital; a 250-bed aeromedical staging flight; and an armed services whole blood processing laboratory. Approximately 1,600 of the medical staff have mobility missions. The deployed staff would be backfilled by the Air Force Reserve's 11th Contingency Hospital staff. A readiness training facility has been established on the grounds of Wilford Hall USAF Medical Center, Lackland AFB, Texas. More than 2,000 members of the staff have received ongoing readiness training and additional members are being trained at the rate of 100 a week.

When our people are not doing specific tasks in support of the mission of the base or training in preparation for their wartime role, they are gainfully employed by providing health care to a significant number of Air Force families. Because medical readiness is our first priority, we have to be ready to practice battlefield medicine from day one with the skilled professionals, the pre-positioned medical assets overseas, and the backfill of CONUS hospitals with Air Reserve Forces, who replace deployed active duty medical personnel.

WARTIME MEDICAL ORGANIZATION

During wartime, we would shift to a four echelons of care system and every Air Force member would have a role to play. The thrust is to provide effective and efficient medical care to casualties in the combat area, to provide rapid evaluation for definitive treatment as required, and to assure early return of combatants who are not severely injured.

The first echelon of care (self-aid and buddy care) is accomplished where the injury occurs. It applies to personnel on or near the individual operating base, and has limited capability such as hemorrhage control, wound protection, and assistance of injured to the next echelon.

The second echelon (emergency care by medical personnel) occurs on or near predesignated air bases. At this level of care, triage and initial stabilization are provided, similar to "emergency room" services. Patients are evacuated to higher echelons as conditions dictate or returned to duty.

Third echelon care occurs at a facility designed to provide immediate general surgical care. These facilities provide care for patients evacuated from second echelon units. We concentrate on stabilizing patients, rapidly returning to duty those who are able, and evacuating patients who require prolonged care to the next echelon. Patients who can be returned to duty within the combat zone evacuation policy limits will remain in third echelon facilities.

Fourth echelon care is provided in large wartime hospitals located as far to the rear of the theater as possible. These facilities are sized in increments of 500 beds. Staffed with most specialties, the fourth echelon facilities are able to provide comprehensive care for wartime casualties. Those who are expected to return to duty within the theater evacuation policy limits would remain at the fourth echelon. Patients who exceed these limits would be evacuated to the United States.

The Air Force is projected to receive heavy casualties early in a war as our overseas bases are believed to be high priority targets. Due to the projected requirement for hospital beds at the onset of hostilities, hospitals, equipment, and supplies must be pre-positioned at their sites of intended use with their core areas, such as operating rooms, set up for immediate operations as much as possible. By pre-positioning hospitals, the Air Force will have medical treatment facilities readily available to treat, stabilize, and return to duty, or evacuate, casualties. In addition, we will be conserving critical airlift resources for the movement of combat troops and munitions. The importance of pre-positioned hospitals is highlighted by the fact that 32 C-141 Starlifter aircraft are needed to transport one 500-bed contingency hospital to a selected overseas location.

In the event of hostilities, staffing for our pre-positioned wartime assemblages will largely come from the CONUS. We intend to deploy primarily active duty medical personnel organized by unit types (e.g., 500-bed contingency hospitals, ATHs, etc.) to staff these assemblages because of their immediate capability to respond to the peak casualty requirement anticipated during the early stages of a conflict. A significant number of Air Force Reserve and Air National Guard medical personnel will also deploy to theaters, but they will also backfill CONUS medical facilities vacated by the deploying active duty medical force.

The Veterans Administration (VA) facilities and the Civilian-Military Contingency Hospital System, now called the National Disaster Medical System, play a significant role in caring for returning casualties unable to return to duty within 60 days of their injury. We administer 20,000 beds in the 14 CONUS geographical areas for which the Air Force is responsible. A preliminary exercise of the local systems has been conducted in each area. We have worked with the Department of Defense (DOD) for the past several years in developing, testing, and implementing this system to meet our wartime needs. We have had extraordinary support from the civilian medical community. Fourteen of our 36 casualty receiving hospitals also serve as National Disaster Medical System coordinating facilities and coincide with primary treatment centers of the VA.

We continue to work closely with the DOD and our sister Services in meeting our wartime requirements. We are building our medical readiness capability as fast as funding for manpower, equipment, and facilities will allow.

WARTIME REQUIREMENTS DETERMINATION

The determination of our wartime requirements is a two-step process. The line of the Air Force determines the projected casualty rates based upon intelligence data (threat analysis), weapons effects, historical data, and other criteria. The Air Force Medical Service then uses the tri-Service computer model and data base of the Joint Operation Planning System-Medical Planning Module (JOPS-MPM) to compute the bed and gross physician requirements. The computer model includes the casualty rates, forces at risk, and specifies the requirements for beds in theaters and CONUS beds for returning casualties.

Physician requirements by specialty are then determined by diagnostic classification, using a tri-Service approved data base and model located at Fort Sam Houston, Texas. We in the Air Force call our process PRISM II (Provider Requirements Inte-

grated Specialty Model). Each diagnostic class contains a predetermined treatment protocol consisting of a series of required tasks, task completion times, and a treater of choice for each task. Air Force-specific frequencies of occurrence applied to each diagnosis are included. The model applies these diagnostic frequencies to the number of patients admitted and determines the number of patients in each diagnostic class. The model then computes the number of physicians needed in each specialty. Admission rates and frequency of occurrence of specific patient conditions vary among the Services based on characteristics of combat.

At present, this methodology has been applied only to physician specialties. As a result of the Defense Resources Board directed study of 1984, the Joint Chiefs of Staff have taken the lead, under direction from the Secretary of Defense, to enhance the JOPS-MPM. This will result in a standard computer modeling technique to be used by all Services to determine global wartime manpower requirements for programming resources. We are full participants in this action.

WAR RESERVE MATERIEL (WRM)

Air Force medical materiel planners have projected WRM needs to support combat operations. Sufficient dollars to meet those requirements are being programmed. The following chart shows our procurement program.

WRM PROCUREMENT PROGRAM

[Major assemblies]

	Fiscal year—			Total
	1984 (accumulative)	1985	1986	
500-bed hospital	15	3	4	33
250-bed hospital	3	—	—	3
250-bed ASF [1]	15	2	2	21
25-bed MASF [2]	30	—	—	30
2d echelon	30	10	24	160
Mobile surgery	12	—	—	12
ATH [3]	21	—	—	26

[1] ASF: Aeromedical Staging Facility.
[2] MASF: Mobile Aeromedical Staging Facility.
[3] ATH: Air Transportable Hospital.

As our program is now, we will have purchased 100 percent of our bed requirements by the end of fiscal year 1990. All of our combat zone hospitals will be procured by the end of fiscal year 1987. By the end of this year, we will have purchased 100 percent of the 250-bed hospitals, the 25-bed mobile aeromedical staging facilities and mobile surgeries, 80 percent of air transportable hospitals, 81 percent of the 250-bed aeromedical staging facilities and 55 percent of the 500-bed contingency hospitals.

CONSTRUCTION: WRM STORAGE

Congress has supported our efforts by authorizing and appropriating funds to construct medical storage facilities that enable us to pre-position and store WRM and deployable medical assemblages both in the CONUS and overseas (such as Germany, the Netherlands and Korea). We have requested six WRM medical storage facilities in this year's program; three in the CONUS, two in Europe and one in Korea.

Locations for which we requested fiscal year 1986 military construction program (MCP) funds in support of our pre-positioning effort are Kimhae Air Base, Korea and Torrejon Air Base, Spain. The MCP project at Kimhae is critical as it will be the only major DOD medical contingency facility available to take care of Air Force casualties on the Korean Peninsula. The Kimhae project is a pre-engineered metal building configured to store and operate a 500-bed contingency hospital, a 250-bed aeromedical staging facility, and a blood transshipment center.

The Torrejon project is requested to enable the existing Torrejon hospital to function as the first 500-bed fourth echelon contingency hospital on the European southern flank by construction of pre-engineered facility for storage space adjacent to the existing hospital.

The three CONUS projects in this year's program are at Davis-Monthan AFB, Arizona; Chanute AFB, Illinois, and Shaw AFB, South Carolina. These are needed to provide storage space for our 50-bed air transportable hospitals and air transportable clinics that may deploy worldwide to support flying operations. They are also needed to provide wartime blood donor centers and supplies and equipment to expand peacetime facilities.

Next year we will be presenting proposals to construct pre-positioned deployable medical contingency hospitals in support of additional Pacific and European theater requirements.

It is important to mention that our construction planning for the replacement of our peacetime medical treatment facilities (MTF) overseas incorporates readiness features in the design. The MTF construction project at Osan Air Base, Korea, exemplifies this concept. Included in the project are the placement of critical services on the lower floor for survivability; the berming of the lower floor for blast protection; an air filtration system; a decontamination area; and other features.

CONSTRUCTION—PEACETIME

Our peacetime construction projects are aimed at correcting significant deficiencies in our existing facilities, to provide a work place for the manpower levels required for medical readiness, and to enable us to reduce Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) costs.

A recent policy decision by the DOD provided us with the capability to program additional scope in medical facilities to accommodate mobilization expansion. The replacement facility at David Grant USAF Medical Center at Travis AFB, California, is an example of this added mobilization capability. For less than one percent increase in scope and cost the facility will be able to increase its bed capacity during wartime by fifty percent. It is scheduled for completion is 1989.

THEATER CAPABILITIES

Theater assets in Europe and the Pacific have improved significantly. With allied support, 500-bed contingency hospitals are now at RAF Little Rissington, RAF Upwood, RAF Bicester, and RAF Nocton Hall in the United Kingdom and Zweibrucken Krankenhaus in the Federal Republic of Germany. We are looking at other sites in Germany and several other countries and some look promising. The contingency hospital at Little Rissington was successfully exercised this past year with a deployment of staff from Wilford Hall USAF Medical Center as a part of Reforger 1985. Wilford Hall was backfilled by the Air Force Reserve's 11th Contingency Hospital staff.

MANPOWER

Adequacy of manpower is a continuing concern and is the major limiting factor in meeting our contingency requirements. Measured against authorizations, our overall staffing for the active force is excellent and projected to be approximately 99% in all corps by the end of this fiscal year; however, we still experience some problems in the mix of physician specialists.

Measured against requirements, we have shortfalls. The following chart shows the current picture:

Corps	Fiscal year 1985 authorized	June 30, 1985 assigned	Percent of authorized assigned
Medical	3,867	3,831	99.1
Dental	1,598	1,566	97.9
Nurse	4,862	4,854	99.8
Biomedical sciences	2,324	2,258	97.2
Medical service	1,186	1,206	101.7
Enlisted	28,847	27,176	94.2
Total	42,684	40,891	96.0

The active duty/Air Reserve Forces split reflects the need to have rapidly available manpower assets to meet early mobilization requirements for the theater of operations.

The Air Force is planning significant medical manpower growth to staff contingency units. Fiscal year 1986 to fiscal year 1991 increases in the active military are from 44,407 to 47,542, an increase of 7%. This growth, if approved, will greatly increase our capability.

At the present time, the critical wartime specialties are surgery, orthopedics, urology, operating room nurses, nurse anesthetists, medical service technicians, surgical technicians and biomedical equipment technicians.

AIR RESERVE FORCES—ARF

The Air Reserve Forces—the Air Force Reserve (AFR) and Air National Guard (ANG)—have a significant medical role in both peacetime and wartime. The size of these forces will double during this decade. Currently, the ARF provide 18 percent of our wartime medical manpower requirements; the programmed manpower build will increase this capability to 30 percent by fiscal year 1991. An important part of this build is in the area of aeromedical evacuation.

Aeromedical evacuation plays a significant role in patient care in both peacetime and wartime. Today, approximately 25 percent of the CONUS C-9 and 67 percent of the strategic C-141 aeromedical evacuation crew member positions are filled by the AFR. If war erupted now, the ANG and AFR would, after mobilization, constitute 90 percent of the authorized tactical and strategic aeromedical evacuation crews. By 1987, that will increase to 94 percent.

In the event of war, the ARF will supply medical personnel to staff many CONUS medical facilities in order to replace deploying active duty personnel. Both the ANG and AFR are undertaking the task of building manpower packages for 250-bed and 500-bed USAF contingency hospitals.

We are continuing a number of initiatives to reduce the shortfalls in staffing. In the ARF our manpower build encompasses two 250-bed contingency hospitals, four 500-bed contingency hospitals, and 250 additional aeromedical evacuation personnel. This build will take us from a present strength of approximately 16,000 to a total of 20,000 in fiscal year 1990.

TRAINING

The training of our personnel for combat readiness continues to receive high priority, through formal courses as well as training at the medical treatment facility unit level. Thousands of Air Force medical personnel, including nurses, have participated in formal readiness training programs such as Battlefield Medicine, Battlefield Nursing and Combat Casualty Care Course.

As mentioned before, our personnel participated in the Reforger exercise where we tested the pre-positioned 500-bed facility at Little Rissington, England. A large medical contingent from Wilford Hall USAF Medical Center was deployed to the facility and set up operations. Wilford Hall was backfilled by the 11th Contingency Reserve Hospital staff.

Dental officers in the Air Force are being trained for a wartime medical readiness role in addition to their traditional role of providing timely and comprehensive dental care. This training is designed to expand their skills to provide adjunctive medical skills necessary for combat casualty treatment care under field conditions, and in the operating room and trauma care environments. All dental officers receive this training. Courses used for this training include Medical Red Flag II, Advanced Trauma and Life Support, Combat Casualty Care, Animal Model Training, and Battlefield Medicine. The success of this effort was demonstrated by the extraordinary support provided by dental personnel in triaging and providing initial treatment to the personnel injured in the Ramstein headquarters bombing in August 1981.

The Air Force has also established a week of medical readiness training for all enlisted trainees prior to their entry into their assigned medical basic training course.

CHEMICAL DEFENSE PROGRAM

We have taken aggressive steps to ensure the USAF Medical Service will be able to fully support the mission under a chemical warfare environment. We are participants in a joint Service agreement with the Army for determining the medical aspects of effective chemical warfare defense. We have two officers assigned to the

U.S. Army's Medical Research and Development Command (USAMRDC), with one serving as Director, Chemical Defense R&D Program. We fully support this program's objectives to sustain mission accomplishment, enhance combat effectiveness, improve personnel survivability and patient care, and minimize performance decrements, disabilities and deaths.

We have recently fielded a nerve agent antidote regiment which has been tested and found to be ten to twenty times more effective than the old regimen. A new nerve agent pre-treatment drug, pyridostigmine, is being procured for pre-positioning in high threat areas of all theaters of operations.

Furthermore, during last April and May we participated in USAFE's SALTY DEMO exercise conducted at Spangdahlem AB, Germany. This was the first integrated base-wide demonstration of air base survivability capabilities under conditions of both conventional and chemical warfare environments. During the exercise we were able to test our medical prototype of an on-base second echelon level of care facility, capable of operating in a chemical environment. Formally, this facility is called a Survivable Collective Protection System-Medical (SCPS-M). It is partially underground and bermed, and has positive overpressure that will filter out most NBC particles. If this facility continues to demonstrate it will meet our needs by allowing us to increase return to duty rates and survivability, we will proceed to procure more in the later years of our program.

CONCLUSION

Wartime medical resource requirements have increased dramatically in recent years due to significant changes in the air threat facing our NATO forces. The attainment of an effective readiness posture is a complex and expensive undertaking. The fluctuating political climates around the world, austere budgets, and manpower constraints present very difficult challenges to the Services in meeting their mission requirements. Despite these constraints, we have made great strides in expanding our readiness capabilities. The major programs we have underway will enable us to meet our contingency requirements in the near future. I wish to thank the members of this Subcommittee for your interest and support in these efforts.

I will be happy to answer any questions.

Senator WILSON. Thank you very much, General.

As stated, the written statements submitted by the witnesses will be inserted in the record.

Gentlemen, I have a copy of the remarks delivered by Secretary Weinberger 3 days ago at the first Department of Defense Health Conference of commanders of military medical facilities in each of the services.

Although I was aware of DOD's emerging policy on medical readiness, I think Secretary Weinberger gave the clearest statement of that policy that I have yet heard. Let me read to you an excerpt from it.

Medical readiness will be the primary criterion for determining the size and composition of our medical corps, medical facilities and training programs. The mechanism for accomplishing this is equally clear. Responsibility for allocation of resources to these purposes is vested centrally in the Assistant Secretary of Defense for Health Affairs.

Dr. Mayer, how does this policy differ from the Department policy of a year ago?

Dr. MAYER. It is not a total departure at all in our policy except for the fact that there is now the requirement that in determining the size and staffing of the military medical facilities, we are going to be required to examine the entire array of military health care facilities, not just the services individually.

In connection with that, we are going to conduct a survey worldwide of all health care facilities. We are going to be required to assign priorities for their refurbishment or rebuilding or replacement without regard to the service identity connected with the hos-

pital. That is, the primary consideration will be the need for that particular facility in supporting the overall readiness mission of the Department of Defense.

Obviously, we will do that in a very close coordinated action with the three services. They will assist in conducting the overall assessment of the health care structures and we will then come together and I am sure it will be difficult, but we will assign priorities for the limited amount of resources that are available to do that kind of work.

CROSS-SERVICE PLANNING

Senator WILSON. The statement "responsibility for allocation of resources is vested centrally in the Assistant Secretary of Defense for Health Affairs" seems to join with your own statement that there have been serious problems. However, I do not intend to blame the medical personnel for what I think are inherently problems arising from inter-service rivalry.

We are not pleased, I will tell you gentlemen, with the fact that we seem to have different logistical systems and different communications systems such that our different branches cannot talk to one another at times when they are in critical need of communication.

I wonder about what seem to be three different medical logistics systems in the three services, and, to quote from Dr. Mayer, it seems clear that this policy is not entirely new. This is the clearest statement and affirmation of what you said when you said there is no unity of command.

Let me ask Surgeons General, General Becker and General Chesney and Admiral Seaton, how does this policy differ from the policy that your respective services were following a year ago?

General BECKER. I will go first. The policy of resource control, which is the new charter for the Assistant Secretary of Defense for Health Affairs, is different from what it has been in the past. We are not fully aware exactly how that will totally play out.

Dr. Mayer discussed the part about the prioritization of medical military construction and that part is becoming fairly clear. We are all working together on how we will grapple with this problem.

Now, the policy of the services working closely together I think has been the policy all along. I don't believe that has changed. The only new thing I know about it is the policy of the resource control or oversight changing from services or the Secretaries of the services to the Secretary of Defense for Health Affairs.

Senator WILSON. Admiral Seaton?

Admiral SEATON. I think if you look at the report of the Blue Ribbon Panel on Sizing, which is one of the places we talked about centralized resource allocation, particularly for new facilities, each of the services did look at their own facilities and makeup their own list of which ones they would like to have improved or even replaced. That list was submitted in the planning process and the Department of Defense did have an opportunity to review it before they submitted the budget. But they really had to exercise more or less a veto to take something out.

Now, as I understand the concept, which as General Becker said, is not fully out, it will be a more proactive, more positive system. OSD will look at all three services and begin to make their prioritization first, rather than have three separate submissions and exerting their authority in a negative fashion.

Senator WILSON. General Chesney?

General CHESNEY. I agree with Admiral Seaton and General Becker, there is not that much basic change in the policy. DOD has always controlled our hospital construction. There have been periods of 10 to 20 years when we have tried to get hospital construction through DOD and have had it vetoed because they did not think it fit in the overall system scheme.

This, I am sure, will continue with closer scrutiny and we will work with DOD to work this out, tri-service, in a better fashion than we have in the past.

Senator WILSON. Senator Nunn?

UNITY OF COMMAND

Senator NUNN. Mr. Chairman, it seems to me there is a fundamental difference here. You are talking about two different things.

One is resource allocation and how you make those decisions in the calm of a budget review. Always DOD theoretically makes those decisions. You can say negative or positive, but it seems to me it is not all that terrible.

What Dr. Mayer is talking about is unity of command in the field. We have been hearing forever that the services always work together. We have heard that on communications for 12 years.

You can say the House and Senate work together, but that is a lot different from unity of command. We do not have it, we are not supposed to under the Constitution, but you are in the military. That is the most important concept.

I have not heard any of you address what Dr. Mayer has said. Not only do you not have it, but it seems from his statement, he cannot seem to get it even though the Department of Defense, the Secretary and Joint Chiefs both signed off on it. It is not happening.

That seems to me to be the question Senator Wilson is asking. I have not heard an answer.

General CHESNEY. Let me say you missed one thing Dr. Mayer said: Full-time command. I would like to introduce Major General Greendyke who is the EUCOM Surgeon.

Senator NUNN. Dr. Mayer said that was not sufficient.

General CHESNEY. Not full time. He is part time. He spends 40 hours a week down there and 40 hours a week on his other job. So, he works 80 hours a week.

Senator NUNN. You are not agreeing with Dr. Mayer then?

General CHESNEY. Dr. Mayer said full time. I am not disagreeing with that at all.

Senator WILSON. What is his other job?

General CHESNEY. Command Surgeon for the U.S. Air Forces in Europe. It is a dual hat job.

There is a full-time Pacific Fleet Commander who also serves——

Senator WILSON. Let me ask a question.

Dr. Mayer, is it possible for one man to do both those jobs or is it even advisable?

Dr. MAYER. Certainly not advisable. The issue has arisen over and over again in the past.

The fact that the Command Surgeon for European Command is an additional duty for one or the other of the service senior physicians has resulted in the fact that the overall needs of the medical department in Europe have not been well represented under the counsels of the European Command which is made up of very senior officers from the various branches.

Now, maybe General Greendyke is doing a splendid job. He is risking his health and durability in trying to do both his major tasks full time, as General Chesney suggested. That is not an adequate way to run a command headquarters.

He needs a full staff for the European Command Surgeon. We have been able to increase the planning staff there by three people which is great because a couple years ago all we had was one and a secretary.

So, I could present it to you that we have had a 3-percent increase, but it is pointless to play those kinds of games.

By the same token, even the fact that General Greendyke is able because his Air Force Commanding General is willing to allow him to devote that much time to this job is a total departure from the way it has been in the past.

When the 7th Medical Commander had the additional duty of being European Commander, that is the Army Commander, the demands of the job of running the 7th Medical Command in Europe, commanding all the hospitals there, was such that he could not possibly be expected to devote the kind of time and energy that a major cross service job requires.

So, we are not disagreeing really, I do not believe. We all agree there needs to be a full-time command surgeon in the European Command. The fact that Bill Greendyke is doing a splendid job right now is wonderful, but that does not get it.

Senator WILSON. Well, it seems clear we need to change that.

It also seems clear that there needs to be considerably more coordination than would appear from a single tragic incident, the Beirut bombing, than has occurred. In the classified part of this hearing we will pursue that further.

Senator NUNN. Could I pursue one other element on this point? I think this is critical when we address the system.

AUTHORITY NEEDED

The question is not just whether you have a man there and he is full time. The further question is what is his authority?

General Greendyke is sitting there at the top and taking the various services and telling them what to do, and he has authority to tell them what to do, and authority to allocate resources and authority to say no, we do not want to put these in the Army hospitals in an emergency, we will put them in the Air Force hospital even though they have a Navy uniform, and that is authority.

The question is. What authority does he have now and is it adequate whether he is working 80 hours a week or 40?

I am sure he is overloaded. What authority do you envision, Dr. Mayer? What is needed?

Dr. MAYER. He has the authority now of any staff supporting officer of the European Commander in Chief. That is to say, he can advise the Commander and get his approval to do what he feels is necessary to do.

Senator NUNN. Can he tell him? Can he give him an order?

Dr. MAYER. No, he cannot.

Senator NUNN. He is not in command. That is not unity of command if you have advice and consent and talk back and forth. That is the legislative process. That is what we have to do to pass a bill.

Dr. MAYER. We call it command by committee.

Senator WILSON. Command by committee?

Senator KENNEDY. Could General Greendyke tell us the advice he has given to the command in Europe that has either been taken or has not been taken?

Or alternatively, maybe he could tell us what request he has made that has not been answered.

Senator WILSON. I think in response to your question, General Becker could answer it. He was, as I understand it, the predecessor to General Greendyke.

General BECKER. I was part-time EUCOM surgeon, third hat, if you will, before General Greendyke.

I cannot recall any instance when I advised General Lawson that he did not take action.

Senator KENNEDY. So, whatever happened on your watch you take full responsibility for?

General BECKER. Yes, sir.

Senator KENNEDY. As the problem has been described in these various reports, all indications are that there has been lack of coordination and lack of central control over resources and personnel.

General BECKER. Due to my position there as EUCOM surgeon, I will take full responsibility.

Senator KENNEDY. You apparently made no recommendation at any time to change or alter existing conditions because you just said that any advice you gave was implemented.

I am trying to find out who bears the responsibility.

General BECKER. We made plans and requests certainly that were not fully implemented. We could not have commanded them either because they require resources and changes to the system.

I would not say that all the things we wanted were given because we wanted a full triservice communications net and the plans and programming have been put into effect to get those kinds of things. Certainly they have not all been implemented.

Senator WILSON. Why not?

General BECKER. Sir, I cannot answer that. There were higher priority items and I cannot answer that. That is a question that would be a question for the commander of European Command.

NEED FOR COMMAND SURGEON

General CHESNEY. Let me answer a bit about command. Command is not a complete and total control.

As Surgeon General of the Air Force, I do not command my medical personnel. If I need something to be done, I go to General Gabriel and I ask him to initiate actions through the major commanders.

If General Greendyke needs something done, he goes to the four-star commander for all Europe and says tell the Army to do this, the Navy, and so forth. In effect, he has as much command as anybody does in the medical field.

Senator WILSON. We are trying to focus this morning on whether the deficiencies in this system have arisen by virtue of the medical commander being unable to secure the kinds of support from the overall field commander or has arisen from the inability of the medical commander in one service to actually obtain the kind of coordination that is necessary between the service medical components.

Dr. MAYER. I would like to support what General Chesney has said. The medical departments exist to support the line and whatever authority we have is derived and delegated by the line.

Senator WILSON. That is understood.

Dr. MAYER. In general, in the course of day-to-day activities when no war is going on and no crisis has occurred, then it is quite proper and possible for the command surgeon to go through his senior line commander and have things take place that are possible.

What gave rise to all this consideration or what brought it to a head was the Beirut incident. That is a perfect example of the fact that there will probably never again in history be an operation that is solely one service.

Part of the Navy Medical Department took care of the Marine Corps which was the first involved in the care of those casualties. Then the Navy Medical Department aboard ship, which is quite different, was involved. Then the Air Force Medical Department was involved and then the Army Medical Department was involved.

Each of them did splendidly. There were, however, complications in facilitating and coordinating the activities of all four services in that emergency situation. It is at such a time that a designated command surgeon has to have direct command authority to tell that Army hospital, you do this, that Air Force unit, do that, that Navy unit, do that, without having to go back to his overall commander in chief and to get permission to do this.

So, the existence of the command surgeon in Europe would not mean there was a little medical dictatorship over there all the time, but it would mean there would be a force consolidation of the requirements of each of the services, force coordination of all their planning activities, and a clear understanding that when an emergency arose, that medical commander commanded everybody who was medical.

It is only in that event that the medical department can give the line the support we are called upon and are expected to give. So, I don't think among us there is any great disagreement with that.

ZIMBLE RECOMMENDATIONS

Senator NUNN. If I could ask one more question here, and I will not interrupt again, Mr. Chairman, but Admiral Zimble's report states very clearly, and I believe this is what you are saying, Dr. Mayer, they recommend that you:

> Establish a joint command and control over medical planning and medical resources in the U.S. European Command, the EUCOM surgeon should be given directive authority over medical elements of the service components, medical plans should be developed jointly and approved and reviewed by EUCOM before their incorporation in the service component's plan.

That is their recommendation. Is that your recommendation?

Dr. MAYER. I totally and absolutely support that.

Senator NUNN. Does anybody have disagreement with that?

General BECKER. I agree. No problem.

General CHESNEY. I agree and support it.

Admiral SEATON. I can't speak on the European Command, but I did serve 2 years as both the Pacific Fleet surgeon and the Pacific Command surgeon.

I do know that the planning process, in terms of identifying shortfalls, is triservice. There is unity of command represented and reposed in the commander in chief of the Pacific Command, a four-star-line officer. I served as his staff medical officer. I was responsible for the plans of all three services coming to the head of the pyramid and being submitted (when those shortfalls had been incorporated) with the CINCs' Op plans.

How to structure the programs that you see every year in terms of the 5-year defense plan is not determined only in Washington. There is in the Pacific Command structured triservice planning in order to identify the shortfalls such as culminated in the fleet hospital program and hospital ship program.

Senator NUNN. Does that mean you agree or do not agree with this recommendation?

Admiral SEATON. I agree in triservice planning.

I do not agree with directive control. I believe directive control fragments just what you are talking about, unity of command.

You cannot have a doctor on the CINC staff directing the orders to hospital commanders in component commanders staffs.

The way it works, I expect you would be familiar with it, if I have a recommendation or see a problem that people out in the field identify as a problem in one of the hospitals or one of the component commands, I can look at it and investigate it as Pacific Command surgeon and go to the CINC, the man with unity of command, and say, "Sir, I think we ought to do this." Then if he agrees, he directs his component commanders who in turn direct their hospital commanders.

I never had any problem in getting to accomplish what was necessary if the man in charge, the CINC, agreed that whatever I suggested was indeed a good idea.

Senator NUNN. I think that is a long way of saying you do not agree with this.

Admiral SEATON. I do not agree with directive control between a unified commander's staff to a subordinate commander's staff.

I believe the Unified Command is vested in the line commanders as drawn in all of our diagrams and exercises.

Senator NUNN. The problem is the line commander's best hold on the set is beyond the hearing's scope, but the commanders in chief in the field do not have control over component commanders as far as surgeons are concerned.

When you say, kick it upstairs because they will stop it, you are saying kick it upstairs where that is a mammoth problem and one of the biggest problems we face in the whole reorganization.

You are saying raise it to a higher level of disunity. That is all right, that is your view. I think it is clear that there is not complete agreement. That is fine, that is what we want to find out.

Senator WILSON. This hearing which is focusing on wartime medical care is a microcosm of a larger problem.

JOINT CHIEF'S RESPONSE

General Toner, I do not want you to feel neglected. It occurs to me that since the line does have to support the medical staff, we need to hear exactly what the Joint Chiefs' response has been to what I think has rather clearly been a failure to coordinate or to resolve conflict between the services.

Maybe I should begin by asking you, and I will also ask Dr. Mayer, Who should resolve these conflicts and what is the Joint Chiefs' direction on that?

General TONER. I do not think I agree 100 percent that there have been great conflicts among services in the provision of medical care or anything else.

It seems to me, having served in the European Command I can speak with some knowledge of how things operate, there is only one person in charge over there—General Rogers runs the European Command without question. If there is a decision that cannot be resolved by the staff, he will make it and I have never seen any issue that was not solved. He has the authority and the ability to do that.

With respect to the authority of the EUCOM surgeon to direct things, I would agree with Admiral Seaton that directive authority is not the way to go. I believe that he has the power on all kinds of normal operations to see that things get done.

The assignment of patients to a given hospital certainly is not something that goes to four stars. It is handled by either the Joint Medical Regulating Office or if it is a big problem like the Beirut incident, it is handled by the EUCOM surgeon. He makes that decision based on medical principles.

I can assure you that the line does not get involved in deciding which hospital a given number of patients should be placed in.

With respect to the Joint Chiefs' role and JCS role in this entire operation, our primary effort is resolving or evaluating the plans that come out of the Unified and Specified Commands.

Senator WILSON. Let me again interject.

It seems to me what you have been doing is evaluating. However, without getting into classified information, and we will do this subsequently, can you tell me who it is and how it is that conflicts are resolved when in fact conflicts exists between the war plans of dif-

ferent services on such matters as the use of a particular medical facility?

We all know that the line commander has the ultimate authority, but we also know that there have been conflicts and that they have not been resolved as they should have been.

General TONER. The way a conflict of the type you described should be resolved is that it should come to the theater commander for decision, and he can make that decision. I can assure you that it will carry.

Senator WILSON. How should it come to his attention?

General TONER. If there is an issue between the services, the medical planning staff at the Unified Command should be aware of that and with the theater surgeon should present that issue to the commander in chief for decision.

Senator WILSON. Dr. Mayer?

HEALTH AFFAIRS RESPONSE

Dr. MAYER. I couldn't agree more in normal peacetime operation. Our job is to save human lives. When there is an emergency situation that requires decisions, right or wrong, but decisive action and coordination of our various capabilities, then directive authority cannot be ignored, it is the principal way to get the job done.

We are talking about situations in war where deaths occur in the first 9 or 10 hours after being wounded. If we have a situation in the Persian Gulf where a ship gets blown up, we are going to have several hundred casualties at one time.

At that point, in spite of the fact I prefaced my remarks by saying we are simply the support of the line, that is why we exist, and certainly General Rogers is in command and General Lawson is in command when General Rogers is not there, I do not question that at all, but there has to be a central operator to whom it is delegated, without a lot of staff work and a lot of coordinating back and forth of the idea. Maybe there is a disagreement between the Navy and the Air Force and it has to be resolved.

Somebody has to be in charge. He has to be in charge when the emergency occurs and be able to make orders, as necessary. Not in peacetime, not in between emergencies, he should not tell Wiesbaden, you are going to take certain kinds of patients, Lonstuart, take others, send others to London, but the minute there is medical demand for services to support our forces, then one person, supported by an adequate staff based on plans previously made and submitted, is going to have to bite the bullet, sit there, take the responsibility and be in charge.

That is all Admiral Zimble's report really calls for. That is all I call for. In the absence of that, the next time there is a major demand for the medical system in Europe, even though we have gone a long way toward improving our planning and coordination, without General Greendyke's having a full-time job, full-time staff and very clear line of authority when it is necessary to operate that part of the military system, the situation is going to be confused again.

When there is confusion in medicine in the early phases of a conflict, people die. That is what we are trying to avoid.

Senator WILSON. Admiral Seaton, you do not disagree with that, do you?

NAVY RESPONSE

Admiral SEATON. Yes, sir, I do. It is just the opposite. Let us take a specific example.

As I understand the questioning, if there was only one deployable system of a certain kind and a conflict broke out, and the question is who would make the decision as to where it goes, no matter what service is staffing that hospital, I think in terms of unity of command, it is basically the commander in chief of that theater, the war planner.

He knows his command. He knows what he is going to do. Certainly the medical officer on his staff should be the one to advise him.

Basically I think it would be fragmentary and disruptive to have a separate command system in time of war.

Senator WILSON. If you don't follow the kind of procedure that Dr. Mayer has outlined, don't you risk precisely the kind of confusion and irresolution that delay patients' care?

Admiral SEATON. I think you are asking a question that has two parts, and Senator Nunn sort of began the first part, whether we are talking personal actions or whether we are talking the system which should be designed to handle it. I believe the system as presently designed, and I will again caveat my remarks as I know it can and should work in the Pacific side, can indeed, does not need directive control of a different command system for medical.

No, it does not.

Senator WILSON. Perhaps your experience in the Pacific has been different. It would seem, though, in the European Command where we have had conflict, history bears out the concern that Dr. Mayer has stated here, but it may be better to pursue that in a closed hearing.

Senator Glenn?

Senator GLENN. Thank you, Mr. Chairman.

Just to follow this up a bit. I will not get into specific names because I think the hospitals are in a particular spot that was in the classified document submitted to us.

We have evidence that in Europe the Air Force said there was one particular hospital they were planning to evacuate if war starts because it was too vulnerable. The Army was planning to move into the same hospital and take up the 500-bed capacity.

That does not show much coordination or authority or anything else. That is right out of Sesame Street. If we are doing all of this coordinating, who is making the decision? Somebody has to make it.

That is dumb when we are doing things like that. Who is responsible?

RESPONSIBILITY FOR DECISIONS

General TONER. I would say in a case like that the theater commander is responsible. That issue, obviously, has been resolved and it should have been resolved much quicker than it was.

Senator GLENN. Has it been resolved?

General TONER. Yes, sir; the Air Force will continue to operate that hospital.

Senator GLENN. I was concerned about authority up the line, too, not just in a theater.

It seems to me we have some basic things we are talking about. We are talking about whether services can even communicate across service lines.

Dr. Mayer, you referred to that in your testimony here. Here we are with all this, we can't even communicate. I congratulate you for your candor in your statement. You were blunt in some of your statements there.

I do not know if you have gotten in trouble with folks over there or not, you probably have. You said there have been some significant steps. You said you are concerned that only small gains have been made in cross service medical readiness plans, and, by the differences among the services' methods of predicting wartime medical manpower requirements.

You said more than 1½ years ago the report accompanying the review of medical readiness in the European Command contained a number of specific recommendations regarding planning activities.

These are so basic to having any medical program, it seems to me because you said these include providing adequate medical planning staffs, reconciling inconsistencies in planning and procedures for the control and use of the aeromedical evaucation system in wartime, establishing joint command and control over medical planning and resources, directing joint utilization of medical resources in wartime, and developing joint medical plans for dealing with terrorist attacks.

Then you finished up that paragraph saying:

> Although a great deal of discussion has taken place in that area over the past year and a half, to date few definitive actions have been taken.

You say you do not consider that acceptable. And there is another thing on manpower requirements, you make the statement the obvious problems generated from these difficulties have been recognized since 1978, yet have proven extremely difficult to rectify.

RESPONSIBILITY IN THE PENTAGON

My concern is not authority in the field. It is whether we have anybody running the shop in the Pentagon who is trying to set these things up. You recognize this.

Do you pass this over to the JCS and they don't do it? They say; "This guy Mayer again." Do they ignore you?

You say this has been 1½ years and SecDef has no authority to see that things happen in the military?

That is a sad indictment of our whole system. I am more concerned than just what happened in Beirut or EUCOM or the Pacific Fleet. I wonder whether anybody is in charge in the Pentagon that is leading this whole thing and getting it straightened out?

I would welcome any and all your comments on that. You say; "Here is what we are going to do;" the SecDef says: "Here is what

we have to do," and you pass it over. You say; "Military, here is what we have to do."

What happens and why do we waste 1½ years and all this baloney going through this, not able to communicate with people? We cannot even communicate back and forth to find out what is going on, know who is in charge.

Dr. MAYER. Sir, the authority is within the power of the medical departments to do. The working relationships that they have developed with my office is such that generally it gets done in my office.

When, however, it involves much larger issues of the entire structure of the military departments and their relationships with one another through the Joint Chiefs and with the Secretary, then we may encounter difficulties.

The most clear example of that is the recommendation endorsed by the Secretary of Defense that a general or flag officer be appointed full time and given staff to be in charge in the European Command. That was passed to the Joint Chiefs.

The Joint Chiefs recognized it and responded that in principle they agreed. I heard nothing more. So, after about 6 months I requested the Director of the Joint Chiefs to tell me what was happening.

He said they were working on it and there were, I knew, some problems in the allocation of general officer and flag officer slots. I was aware of that. There is a very strict limitation imposed by the Congress on the number of such positions.

Six months later I queried again and got essentially the same kind of response. I suppose it could be said that it is my job, I have to go running back to the Secretary and tell him the Joint Chiefs are not doing what I want them to do. It is not just the Joint Chiefs. It is a very complex structure.

I do not mean to sound defensive about it, but there are just a certain number of medical Generals in the Army, for example. The Army over many years has established where those medical Generals they feel are most needed. Now comes along a new boy on the block; namely me, and I say, well, some one of those medical Generals is less important than a medical General in Europe.

So far, while they may feel that could be true, they have not found any, nor has the Navy, nor has the Air Force. I do not say that in a blaming sense. But there is some savior of unity of command at the Pentagon level as you correctly identified. There is no czar and I have no desire to be one.

We have had many recommendations that we should bring up, establish a defense health agency. The major issue in the establishment of a defense health agency, was that somewhere we get a four-star medical General and he would command everything.

One of my major problems with that is, are they going to command everything? If they are going to, then they ought to do it. I do not think they ought to do it in such a way that he would command facilities in peacetime except he would not command the personnel. The Surgeons General would still assign the personnel.

Senator GLENN. The SecDef decides this and they pass it to the services and they say, do it, and it does not get done.

Is that insubordination? It seems to me if the directions are going out and they go through the JCS and they cannot even com-

municate with each other in a situation, I find that unbelievable at this stage.

Then you have all these very basic things you listed which are so fundamental, I am glad you list them, but they are fundamental. Yet you say today few definitive actions have been taken:

> Although a great deal of discussion has taken place in an area over the past year and a half, to date few definitive actions have been taken.

Now, who is in charge? They are either taking direction or they are not and that is very fundamental.

Dr. MAYER. I can only agree.

General TONER. May I comment?

Senator GLENN. Yes.

PROGRESS MADE—EUCOM READINESS

General TONER. With respect to all those issues that were raised in Dr. Mayer's statement, I can assure you that with respect to every one of those, action has been taken. In the entire EUCOM readiness report, there were over 61 different recommendations. Over half of those have already been closed out or will be closed out by the end of the year.

Now, we have taken a lot of actions. Some of these are very serious problems and very difficult to solve. The communications problem is a point at hand. We have a difficult problem in resolving all communications problems. It is going to take some time to do it.

I can assure you these things are not being ignored. They are being worked and worked regularly and hard.

Dr. MAYER. I said the same thing in my opening statement as General Toner has said. There has been good progress in many areas. We could affect the entire group of 61 recommendations.

We have more medical planners in Europe, just as I said, and we are very pleased with that. It is not a definitive response. We have agreement in principle that there ought to be somebody in charge, but we do not even have anybody on the horizon. I do not consider that a definitive response.

I do not think there is clear insubordination at all. As General Toner suggests, solving communications problems gets into the Defense Communications Agency, gets into the allocation of frequencies on radio, gets into massive procurement of communications equipment, things far beyond the ability of the DOD medical community to influence or even beyond our knowledge, I realize that.

I am impatient for things to take place because the kinds of things that were found as a result of those two studies are, in my judgment, things that should be addressed more promptly than they have been addressed.

Senator GLENN. Do you think service parochialism got involved in the Beirut thing?

Dr. MAYER. I think it is possible, although we have to agree on what we mean by parochialism. I think surely people in each of the services quite justifiably feel most secure and most comfortable in what their services are able to do. They know what it is. They have experienced it.

It is possible in making decisions on the ground, for example, at Rhein Main Airfield where the patients land, as to where the pa-

tient should go may have been influenced by the service loyalties of people on the ground making those decisions.

I have heard alleged and I have read the reports that say, yes, that is what happened. I was told by senior Army officers very soon after that in Europe, yes, that is what happened. Later some of the same Army officers said to me that is not what happened exactly.

All that sort of thing is simply a further illustration of why I think in an emergency there has to be very clear authority.

DISTRIBUTION OF THE CASUALTIES

Senator GLENN. We have a memo from one of the Army colonels over there concerning distribution of the casualties there. It was made available to the committee. It has some rather serious criticisms. It involved the distribution you talked about. We quote an Air Force General as saying: "Those MEDEVAC planes are mine and I will decide where they are to land."

General Becker, you were command surgeon in Europe at the time. Were the initial distribution of casualties handled by the Air Force?

Were you in charge or did you turn the decision over to the Air Force?

Wouldn't EUCOM officials know better than anyone else what medical care was available throughout the command and, therefore, more qualified to determine which casualties should be treated where?

General BECKER. Yes, sir, unfortunately, I was in Italy at the time. The Deputy, the acting or part-time EUCOM surgeon was General Hansen who was the Air Force surgeon. He took over and acted in the name of EUCOM surgeon. He was not acting in his Air Force job. He was in constant contact with General Lawson, the DCINC of EUCOM.

I was very privy to that incident and I investigated the incident. If you would like, I could comment on the incident of the distribution of the casualties.

Senator GLENN. I think if we could have that submitted for the record because we have a whole host of things to go through and we have not even gotten through our first questioning period yet.

Maybe we could have that submitted for the record later.

[The information follows:]

BEIRUT CASUALTIES

After in-depth interviews with Colonel Ward, U.S. Medical Command, Europe; Colonel Pardi, Chief, Professional Services, Frankfurt Army Regional Medical Center; General Hansen, U.S. Air Force Surgeon, Europe; Colonel Signorino, Commanding Officer, U.S. Air Force Hospital Wiesbaden and Colonel Bailey, U.S. Air Force Triage Officer on site at Rhein Main Air Force Base, the following facts are presented. Primary receiving hospitals were Landstuhl Army Regional Medical Center, Frankfurt Army Regional Medical Center and U.S. Air Force Hospital Wiesbaden. Triage teams from each of the primary receiving hospitals were at Rhein Main when the two aircraft arrived from Beirut on 23 and 24 October 1983.

Sufficient air and ground ambulance support was on hand at Rhein Main to transfer the arriving patients to the receiving hospitals. The distribution of the patients was as follows:

Distribution of C-9/C-141 patients: (1) Landstuhl Army Regional Medical Center 9/8; (2) Frankfurt Army Regional Medical Center 1/2; and (3) U.S. Air Force Hospital Wiesbaden 13/3.

There was no question that Colonel Bailey was the Triage Officer in charge that night when the first C-9 was unloaded at Rhein Main. He was fully aware of this, as were the other medical personnel on site. Colonel Bailey clearly knew and understood his guidance from General Hansen and Colonel Signorino. His mission, as he understood it, was to sort the patients, send the head injuries, burns and chest cases to Landstuhl and divide the remaining patients among the three hospitals in the area. There is no indication that he was directed by anyone over him to fill Wiesbaden first, as was alleged in the 7th Medical Command report.

Colonel Bailey believed he was going to receive over 100 casualties before the night was over and knew first hand the capabilities of the Wiesbaden hospital where four operating room suites with at least four surgical teams were ready to go, plus three orthopedic surgeons. Colonel Bailey triaged the serious patients first and sent them to Landstuhl, as was appropriate. He sent an oral surgery patient to Frankfurt and fully intended to send the next group of patients, which he expected in the next few hours, to Frankfurt. Colonel Bailey did not overtax the capabilities of Wiesbaden hospital, as was alleged. This was borne out by the fact that all four operating rooms at Wiesbaden were only in use for a two hour period that night. Early the next morning only two patients remained in the intensive care unit and both were alert. There was never a surgical backlog on the 23rd and 24th of October at the Wiesbaden hospital, contrary to the allegations.

This series of events does point up the problem of using an officer in charge of triage who is thoroughly knowledgeable about one hospital and only vaguely familiar with the surrounding hospitals. His natural inclination is to use the hospital he is familiar with and I believe that this is what happened in this case, rather than a case of service parochial interests.

Senator WILSON. Senator Nunn?

Senator NUNN. I have spent more than my 10 minutes in interruptions. I will waive and come back later.

Senator WILSON. Senator Kennedy?

ZIMBLE REPORT

Senator KENNEDY. Thank you, Mr. Chairman.

I want at the outset as a member of the subcommittee to express my appreciation to you, Mr. Chairman, for holding these hearings. I think they are enormously important. I think they have been incredibly instructive, certainly to me and hopefully to the other members of the subcommittee.

I regret that we are not able to let the American people know more about the state of our medical readiness in the military. We can look back at the way in which our various committees have allocated resources, and perhaps we have not been as responsive as we should have been. We all bear some responsibility as members of the Armed Services Committee in not meeting that challenge and in not bringing these matters up on the floor.

But I find this whole situation absolutely appalling. I was reading just the forward of the Zimble report where he says that the American people are told that its leaders have prepared ways to care for and treat their sons and daughters in time of war.

Then he says:

> Our leadership tells our military commanders we will sustain their forces and tells our troops that we care. The last is most vital. In the absence of medical readiness, we can have no assurance that our troops will retain their will to fight which is the crucial factor in the equation of victory.

But the fact is that today we are unable to care for more than 2 in 10 of the casualties predicted in the event of conventional war in Europe because of our neglect of medical readiness.

I cannot believe that the parents of American sons stationed in Europe know that this condition exists or would accept it if they

knew. I just cannot believe it. I was absolutely appalled to read that fact.

Then you read further through the Zimble report, page after page after page is marked unclassified but those provisions that indict the system most directly are stamped secret. For the life of me, I cannot understand why—other than gross embarrassment—these secret classifications are put on there.

I think that it is a disservice to all of us on the subcommittee who care about this issue, not being able to use these documents. This is a very comprehensive report. Page after page of this is unclassified, and then suddenly, some of it is stamped confidential. And it is those provisions that deal critically with the situation that are stamped secret.

You do not really have to wonder very much about what is really in this report. All you have to do is take something that is unclassified, which I have here, to see how things are: in terms of meeting our requirements for certain medical specialities we fall short: Anesthesiologists, only 27 percent of our requirements; orthopedic surgery, 27 percent; surgery, 27 percent.

But these are precisely the kinds of professions you need in a wartime situation. They have satisfied the OB/GYN requirement at 98 percent.

I want to commend the members of this panel for their candor.

I have heard more honest differences today in terms of expressing your views on matters than from any of the panels I have ever heard that included representatives of the services. I have found this very informative and helpful even though we have been able to touch only the surface of this issue.

I do not think any of us can help but be impressed by your efforts to deal with this. But as I was listening to the Surgeons General, I was wondering if we had the right people here. All of you want to work on these issues and problems. There are other people that should perhaps be here.

I will do my best to find out where these blockages come. When it comes on down to that room when the services are whacking up resources, they are not whacking up enough resources when it comes to this function, and that is frightening.

Perhaps this problem says something about our commanders, about their misplaced priorities in terms of military personnel under their command. I hope it does not. But I do not see a lot of clear evidence on the other side.

I haven't heard much here that would indicate that on X meeting, the Joint Chiefs decided to fight for these kinds of resources that the Congress is not producing. I think this report ought to be required reading for the members of the JCS, quite frankly.

I cannot believe that any person in command who served in the military with distinction can possibly tolerate this situation. Although we have serious problems in terms of resources, this matter is, I think, just absolutely appalling. And we have known about it for some period of time.

I think the questions about command and control have been ventilated during the course of these hearings.

It seems to me that one of the other important questions is this: We have a military health establishment that must serve the non-

wartime needs of our military at the same time it accomplishes the readiness mission.

That peacetime function may be essential in terms of trying to retain personnel in the military. That is a key element. Any of us who have been interested in the quality of our military service understand the importance of that particular function. I am all for it.

But the other thing that we have to recognize is the importance of our wartime capability, and it is illustrated in the European theater very, very clearly and I think very powerfully. Our military medical establishment is suffering from dramatic shortfalls in one of the most significant and important areas of our responsibility in trying to provide for our military personnel.

PEACETIME RESPONSIBILITY

I know you addressed this, Dr. Mayer, in your statement. I have read it. I know that you have shown sensitivity to it. Let me come at this issue from a somewhat different point of view and that is what might be able to be done in terms of trying to meet the sort of nonwartime responsibility that we have for our military personnel.

You said our reliance on our direct care system to accomplish both wartime readiness and peacetime mission has placed significant strains on our ability to accomplish either mission. Then it seems to me that our greatest challenge is to sort out the wartime readiness mission from our non-war health care functions.

As part of the effort to sort out peacetime from wartime, what would be your reaction to some kind of pilot project run by the Army or one of the other services for the families and dependents, say, in a particular geographical area, perhaps the Washington metropolitan area, consisting of their entire health care needs—those that are currently covered by the military—to be covered by the civilian health care system and available in a comprehensive way to dependents. Such a pilot would give us an opportunity to compare the cost, benefits and quality of care and to see what the impact might be of "civilianizing" military medicine in terms of the military personnel?

What I am thinking about is providing peacetime military needs in the civilian area with effective kinds of quality control to find out if we are able to do that, at the same time that we are trying to meet our responsibilities in gearing up our military readiness capabilities?

Could you conceive of perhaps some kind of pilot program in that area so that we could have at least information on how best to be able to deal with the conflict which I believe is a conflict between peacetime and wartime allocation of resources.

DEMONSTRATION PROJECTS

Dr. MAYER. Yes, sir. In fact, we have already three pilot projects going to explore the use of a contractual relationship with health maintenance organizations in three different cities to provide the care for our dependent personnel.

We have been watching this long enough to see that so far it does not indicate any real cost savings, but it does result in great beneficiary satisfaction. It apparently increases their access to care.

We are on the brink of initiating three other pilots which will in varying ways and in varying degrees take advantage of the resources that exist in the community, particularly if our resources in that given community are being overstressed.

So, we have a number of demonstrations either underway or about to be launched to explore that very area. We do not want to deny the military dependents or the retiree or his dependents immediate and unlimited access, particularly in an emergency, to any military hospital.

We do not want to restrict the activities within our military hospital only to military persons on active duty because in peacetime that would not provide a sufficient workload to keep a well-trained, highly motivated, skilled medical force in place.

So, we need the medical professional activities generated by the requirement to take care of these other groups.

The question that arises is how much of that is relevant to our medical care and how much may not be. We are with great earnestness deliberating and consulting and arguing and ultimately, trying to establish just what the mix ought to be within our own hospitals for purposes of keeping the doctors well occupied, but also maintaining our very excellent training program and considering what parts of our system could be farmed out.

Maybe instead of just the general CHAMPUS Program, we could go out to the community and purchase the medical services needed. It might be feasible to initiate some contractual agreement with hospitals that are underutilized or provider organizations or HMO's.

As you know, health financing is undergoing a revolutionary change in this country. We intend to take the fullest possible advantage of this.

Senator KENNEDY. I would hope, Mr. Chairman, we could keep abreast of those. I do not want to create additional paperwork, but it would be helpful if you could give to the subcommittee what pilot programs have been commenced and at least what your initial kind of reactions are.

Dr. MAYER. Yes, sir.

Senator WILSON. If I might suggest, Dr. Mayer, at our hearing Tuesday, which is on peacetime care, we will be very interested in hearing details about the three pilot programs.

DOCTOR REGISTRATION

Senator KENNEDY. Given the failure of being able, evidently, to attract particular specialties that I mentioned before, in anesthesiology, surgery and orthopedic surgery, and the fact they are at such a low level in terms of the active duty staffing requirements, are you considering making a request for a doctor registration in case we get into conflict so that we will be able to fill these particular functions?

Dr. MAYER. There are certainly among our colleagues individuals who believe that that would be the only possible way to meet the physician shortfalls in specific specialties.

I do not wholly subscribe to that idea at this point. I think that our efforts to attract physicians in the specialties that are particularly needed in wartime are hampered, obviously, by the fact that we cannot pay the competitive wages that neurosurgeons or cardiac surgeons can get in a community.

There are a number of ways to approach the solution to that problem, some of them through the Reserve forces, and I think we have made great progress in attracting physicians in the Reserve.

We are far from accomplishing all that we wish. I think that, to plunge to the conclusion at this point, that the only alternative is a registration system for physicians is not justified.

Senator KENNEDY. General Becker?

General BECKER. I take the opposite view on that. I believe we should at least register and have on tap the health care professionals we need in time of conflict. The figures you give are a problem, no doubt about it.

One must remember that OB/GYN surgeons are also trained in abdominal surgery and we fully intend to use them in wartime to assist the other surgeons.

We know there is a major problem in the surgical specialties. One solution for that is in the reserves and we are working on some initiatives in that area.

Senator KENNEDY. I am not sure if I were in the front lines with doctors who are specialists in OB/GYN that I would want that particular person to be operating on me. Maybe others have a different view about that.

CLASSIFICATION OF THE ZIMBLE REPORT

Can I ask, Mr. Chairman, has the staff found a reason why this particular document was so heavily classified?

Senator WILSON. That is one of the questions I have not yet asked of Dr. Mayer. Why in the summary of both the Zimble report and the PACOM report, describing specific medical advances, did they start unclassified and end up being classified?

Dr. MAYER. We in the medical department did not classify that.

Senator KENNEDY. Just to finish up on this point, is there in here, Dr. Mayer, anything you feel should not be available to the general public?

Dr. MAYER. Yes; I think some of the comments in the report relate to actual operational planning and those very limited parts of the report we did classify when the report first came through. We didn't, but they were classified and we saw no problem with that.

As far as the further classification of the information is concerned, I have no first hand knowledge and no control whatsoever over that process.

Senator WILSON. General Toner, do you want to respond?

General TONER. Yes, sir; the overall report, once it was available and completed, was classified secret. OSD Public Affairs sent it to

the Joint Staff with the request it be given a paragraph-by-paragraph evaluation as to classification.

The classifications that you see marked in the report subsequent to the original publication were done by the Joint Staff. Those particular classifications were based on the fact that it was felt that these passages that are so marked dealt with military plans, military operations, our vulnerability, our capabilities, and the capabilities of our system.

That is the reason that they were so classified. That recommendation was forwarded to OSD and it was subsequently approved at that level.

Senator KENNEDY. As I understand it, Dr. Mayer, you indicated that outside of particular areas involving actual operational planning that you classified, you did not classify any other areas; is that correct?

Dr. MAYER. That is right. Obviously, as the General said, there are paragraphs included in the overall document that were secret initially. As a practice, we put a security classification "secret" on the whole report.

The actual determination as to what had to be classified within that and any further elaboration of that are not our province.

Senator KENNEDY. Obviously, an additional classification was imposed; is that correct?

General TONER. Yes, sir; this classification was the overall document.

Senator KENNEDY. Page by page, not overall document at least on my copy here. Some stamped secret on some, confidential on others.

General TONER. Yes, sir; that was the result of the evaluation that was made, that was requested to be made.

Senator KENNEDY. Can you give us more of an idea why?

General TONER. I can only say it was the opinion of the Joint Staff that paragraphs that were classified would do us harm and danger if released. I am certain that there are those who would disagree with that, but that is the basis for the classification of the document.

Senator KENNEDY. From whom are we keeping this information? From the parents of young people serving in the forces, or from the Soviet Union?

This is appalling. This is appalling. But I can see why you might want to keep this information away from parents—if I had a son over there . . . But, boy, I tell you just in terms of reading through this document, when it has some of the most embarrassing criticisms marked "secret", in terms of being prepared in a key area involving support of our personnel, I think it is outrageous and intolerable.

I wish we could get the people up here that used that stamp. I think it is absolutely appalling.

I would like to work with the chairman to see how we can try to figure out some way we can get a review of this report and see if we cannot get further release of this material so that we can at least raise this issue in terms of public debate and discussion and hopefully be able to get the kind of support for the requirements that are needed.

I am absolutely convinced, since this thing is now tucked away in a classification, that the issue is not getting the priority, it is not getting the kind of support it should. This is no disrespect to the Joint Chiefs, but they will be hearing about it in our next session of this hearing in any event.

I will work with the chairman to see what can be done.

I thank the chairman.

Senator WILSON. Dr. Mayer?

Dr. MAYER. May I make one very important observation in connection with what Senator Kennedy has been saying?

The report was looked at very carefully. I can't second-guess those people who decided what is in the best interest of the security of the United States.

I do know the report was very carefully examined by the Joint Chiefs, much as I said in the early part of my statement, we have, as a direct result of this report and of the efforts of my immediate predecessors in office, gotten the very favorable attention of the Joint Chiefs and of the senior staff in the Pentagon so that there has been a vast improvement in the amount of overall military resources that were given to us, specifically to meet the medical readiness needs, over $500 million this year and over $2 billion between now and 1990.

As General Toner said, it is true that the vast majority of recommendations, to quote from my own opening statement, the vast majority of recommendations have been acted upon. Not all of them and not, in my judgment, some of the most critical, but I don't mean to imply for a minute that report has been ignored or has not had a very salutary effect within the services and within the DOD on directing resources toward achieving an acceptable degree of medical readiness.

Senator WILSON. Thank you, Dr. Mayer.

It is my intention shortly to go into closed session. I don't know if you are prepared today, but it seems to me, General Toner, that while we understand fully the necessity to safeguard vulnerabilities and capabilities, to use your phrase, there are parts of this that do not seem to require the classification. That is what we will pursue with you in a closed session.

Before we proceed to a closed session, there are a couple of points I don't want to leave.

I think one major theme comes through this, notwithstanding some fairly rosy statements, particularly in the Navy and Air Force statements, about those services capabilities in medical planning. Clearly, the Army's statement is a less rosy statement in that it says that only 82 percent manning of its medical units, using its manpower in the aggregate, is presently achievable.

Clearly through all of those is the problem of the mix. It is obvious that in time of war, combat surgical specialties, which command such high civilian compensation, will be our greatest and immediate need. We have developed a difference of opinion here which I think we can respect.

Let me ask this: Dr. Mayer, if you hope to remedy the shortfall in these critically needed surgical specialties through the use of more aggressive recruitment of these specialties in the reserve program, have you set a goal and a deadline to achieve that goal? Are

you not, if you don't meet it through your recruitment efforts, virtually required to take a very serious look at peacetime registration in order to assure yourselves that you are going to have those specialties at a time of need.

Dr. MAYER. We have begun the process, sir, to evaluate, to look at——

Senator WILSON. And let me just say this. I can understand how that might be classified if we are talking about the actual numbers, but I think the principle may not be, so I would not ask you to disclose publicly the deadline, if there is one, or the stated goal, but I do think that that needs to be addressed.

Dr. MAYER. We are addressing it by turning the attention of all three services directly on all the factors that influence the final number of physicians in any specialty and those factors include the number of applicants for active duty who happen to belong to those specialties.

They included the number of people we are training in those specialties. They include the numbers that we lose periodically in those specialties and putting all these factors together we are in the early phases of attempting to set forth plans that can have time-phased goals attached to them.

We are not as far along as perhaps we might be, but at least the process has begun.

Senator GLENN. If the chairman will yield for a second, is there any reason why you can't give us those figures? Those are not classified. We have had them in the past.

Dr. MAYER. I just do not have them memorized.

Senator GLENN. You can submit them for the record. That is open information, not classified.

[The information follows:]

MANNING LEVELS FOR WARTIME PHYSICIAN REQUIREMENTS

The following data shows the percentages of wartime requirements for various physician specialties that can be filled with currently available assets:

Percentage of total wartime requirements that can be filled with current assets

Specialty:	*Percent*
General surgery	38
Orthopedic surgery	32
Other surgery	55
Subtotal—all surgery	41
Anesthesiology	48
Psychiatry	85
Radiology	92
Other medical specialties	70
Total all physicians	62

Even though there has been significant growth in the numbers of health professionals, both in the active and reserve forces, a serious shortfall of health professionals to meet the readiness needs of the military forces persists. Positive steps are being taken by the Department of Defense to resolve these personnel shortfalls. These initiatives include the setting of objectives for recruiting by specialty in the reserve forces, establishing and maintaining training programs that are in support of readiness, evaluating service budgets on the basis of their contribution to medical force readiness and preassigning members of the individual ready reserve to active component and early deploying reserve component units.

Senator WILSON. Senator Glenn?

MEDICAL MANPOWER REQUIREMENTS

Senator GLENN. A couple questions here on medical manpower requirements. We have some big differences here on what the services estimate they need in different areas.

For instance, you point out that to staff 1,000 wartime hospital beds in the United States, the Army predicted it would require, and this is in the United States, would require 106 physicians, the Air Force 166 and Navy 392. That is a tremendous difference.

Is there a different basis on which we are estimating these things?

Dr. MAYER. The process for estimating our manpower requirements has been different in each of the three services.

Senator GLENN. Are we getting together so that we have a handle on this?

Dr. MAYER. We are now beginning to use a consistent manpower planning module.

Senator GLENN. Is that in effect now or has it just been suggested to the Joint Chiefs and has not gotten any further?

Dr. MAYER. It has been directed to the medical people in the three services. They are all aware of it.

Senator GLENN. Are they using it?

Dr. MAYER. It is a very complex thing to use. Yes, we are beginning to use it.

Senator GLENN. That one got through. It is actually downhill and the authorities, then, are using it?

Dr. MAYER. Yes; the Joint Chiefs did not care whether we did that or not.

General TONER. I might say the Joint Chiefs took a major role in bringing this together with all three services and expanding the existing medical planning module so that it could accomplish the functions.

Senator GLENN. We have learned about a real breakthrough this morning anyway.

What is the progress you are making on these figures Senator Kennedy quoted a moment ago and that we referred to also a moment ago?

General Chesney, in your opening remarks you talked about the fact instead of these 20-some, soon you will be up to 43 percent and soon you will be up to 62 percent. That is not very encouraging to me, frankly, that we are only going to have 60 percent of what we need out there sometime.

Let me add this. What can we do to help you out in this?

General CHESNEY. Sixty-two percent is primarily equipment and supplies and is what we will have on order by the end of calendar year 1985. We do not have all of it in place yet.

Senator GLENN. That is equipment?

General CHESNEY. Yes; we have 70 percent of the people we need. People are actually better than beds right now in the Air Force.

Senator GLENN. How about personnel specialties, doctors, nurses, operating room people? Are you up to speed on those?

General CHESNEY. We need about 4,600 doctors onboard the day our war starts. We now have 3,831. Our mix is not right. We do

have plans to use people in things that they have not been doing in the past. We are training those people for that type job.

We have a wartime skill training program we are training obstetricians to take care of belly wounds. Twelve percent of our active duty personnel are females and we are told it will go to 20 percent, so we still need some care of women.

Senator KENNEDY. I think we want the physician in terms of function. We have plenty of dermotologists, but we need surgeons. I think we are now talking about those physicians who are essential in terms of wartime.

Maybe you can just do it in terms of vital functions rather than the whole laundry list.

General CHESNEY. We recently asked the Rand Corp. to do a study on physicians in wartime and that very sort of thing. They estimated we could only keep several hundred surgeons busy during peacetime and the rest of them would be very bored not having anything to do, and become ineffective.

So, there is really a limit as to how many surgeons we can keep onboard. That is sort of why we have gone to mixes of other kinds and then tried to train them over that. It does not make sense to have four surgeons at a little base where you need a surgeon and a half to do the work today.

Senator GLENN. In other specialty areas are you more dependent on Reserves being brought in, then, from civilian life if war starts?

General CHESNEY. We would have Reserves that would come within a month, but we need these people onboard the day war starts.

Senator GLENN. If you went to war, it seems to me you would be far more dependent on Reserves than almost any other military specialty.

General CHESNEY. Our game plan is to ship our active duty people overseas and backfill our CONUS hospital with Reserves. That is our game plan.

If we don't have the right mix, we are going to have to work and do what we can today. As they build, we will be in better shape to take care of the specialty mix problem.

Senator GLENN. What is your readiness status in terms of medical units?

General CHESNEY. Our C status we will discuss in closed session. As I said, we are 43 percent today in Air Force in-house ability to take care of our casualties and with some host nation support, we are almost there.

Senator GLENN. Can you tell us in open session what are the main constraints on your medical unit readiness?

Is it personnel equipment or training?

General CHESNEY. Equipment.

Senator GLENN. Equipment?

General CHESNEY. Yes, sir, today. In a few years it may be personnel.

Senator WILSON. Let me ask a question. The Air Force's plan to deal with a major conflict would be to take your Active duty medical personnel and put them in the forward areas?

General CHESNEY. Yes, sir.

Senator WILSON. And fill in your CONUS slots with the Reserves. I understand the Army is going to do just the reverse, that you are going to send Reserves forward and hold your Actives back.

General BECKER. No.

Senator WILSON. At least the percentages are substantially different.

General BECKER. There is a difference in the mix. Most of our critical specialties from CONUS hospitals will immediately move to Europe in event of a major scenario. There will be reservists that will be in the flow to support Reserves in Europe.

It is both an application of Active and Reserve. We are 70 percent dependent on the Reserve components So, we are highly dependent on the Reserves.

We are talking about a very major war with the Soviet Union on the continent of Europe. We are not talking about a small war certainly. The Active Force is not nearly large enough to take on a full-blown war in Europe.

Senator GLENN. How do you stand on the fundamentals like surgeons and operating room nurses?

General BECKER. I have those figures. We are 84 percent overall. That includes the Reserves and that is misleading because we have a specialty mix problem and in anesthesia, general surgery and thoracic surgery we are 51 percent of those requirements. We are short 1,932.

Operating room nurses, anesthesia nurses and medical-surgical, we have 53 percent. That is 47 percent short.

Enlisted specialties, there is a 58-percent shortage of those in practical nurses, psychiatric, orthopedic, and respiratory therapists. So there is a mix problem.

Senator GLENN. Overall rough figures are about half of what you need?

General BECKER. Of those critical specialties. That includes Active and Reserve. Active we are in a lot better shape on that, but in the Reserves is where we need to do a lot of work.

We have some incentives that we have proposed and have been accepted by the Army staff to fix that. They will need congressional support because they require some dollars.

Senator GLENN. Are there different estimates of combat casualties?

Admiral, why was your need for people, for hospital beds, so much larger than anyone else?

Admiral SEATON. As Dr. Mayer and General Toner said, we are trying to clear that up to get into sync with everyone else by utilizing the Joint Chiefs' medical planning module which is an example of how the services work together using a single module for all three services.

Our problem was when you have a ratio, of doctors per beds, you have a numerator-denominator. In our beds in the denominator we were not counting light care beds, convalescent beds. That gave us a much higher ratio.

The second thing, we counted in the numerator our replacement physicians who are still residing in our CONUS hospitals. That seems to be the reason why we have something that is obviously

different from the other two services and basically it is getting corrected.

Senator GLENN. In your casualty estimating procedures, and this is an important one, do you factor in the NBC factors, nuclear, biological, chemical factors?

Dr. MAYER. The medical department does not estimate casualties. We receive our casualty estimates and then we estimate requirements to meet those estimates.

Senator GLENN. Who makes those casualty estimates?

Dr. MAYER. The services individually.

General BECKER. The Army does this through their total Army analysis computerized scenario. They do not at the present time play the NBC casualties, NBC warfare as I know it.

Senator GLENN. They do not include those in your casualty estimating procedures?

General BECKER. That is correct. I could be wrong on that. We can provide that for the record. As far as I know, they do not.

[The information follows:]

NBC CASUALTIES

That is correct. The Army generates casualty estimates from a dynamic warfight simulation process that is currently limited to conventional warfare only. However, the Army is developing an integrated warfare simulation capability, including chemical and nuclear warfare. That simulation capability is expected to be available next year.

Senator GLENN. Is that realistic, in your opinion?

General BECKER. No, sir, it is not realistic at this time.

Senator GLENN. We close our eyes and that trouble will go away?

Do all the services operate on the same threat briefings and threat analysis in making your combat estimates?

General BECKER. We use the threat briefing, the Army does, the one that is provided by the Defense Intelligence Agency. I am sure it is the same one across for all the services.

Senator GLENN. It surely would include nuclear?

You do not make your medical requirements on any basis that we might get into nuclear war?

Dr. MAYER. That is correct.

Senator GLENN. This is all conventional war we are talking about? If we go to nuclear war, all bets are off as far as medical?

Dr. MAYER. Yes, sir.

General BECKER. I do not think that is any different from the equipment lost during the war or anything else, other combat service support and replacement of ammunition, et cetera.

I am not sure about that. It is outside my field. Maybe General Toner can speak to that.

General TONER. That is correct. We don't do our attrition or casualty rates based on nuclear war at this time.

Senator GLENN. Or chemical or biological?

General TONER. No, sir.

Senator KENNEDY. Do you take into consideration even in a conventional war that your hospitals might be hit when you think about number of surgeons?

Are you dealing with treatment of casualties in the belief that existing medical facilities will continue?

General BECKER. In the Army very little attrition, a very small percentage is allocated to war damage. Maybe less than 5 percent.

Senator WILSON. A small attrition of personnel?

General BECKER. And equipment.

Senator KENNEDY. From a military point of view, is that realistic? Isn't somebody liable to be around?

General BECKER. I don't believe it is totally realistic. The hospitals are protected supposedly by the Geneva Convention. We could certainly take large losses in medical personnel in the division area.

But in the corps' rear I can't speak for the people who decide these things, but it seems to me now with the better missiles and things that the enemy has that we are certainly more vulnerable.

Senator GLENN. It seems to me our casualty estimate procedure is a conservative one from what may actually happen in war. That would be whether we go NBC or not.

General BECKER. Yes, sir, it is based on a very intense type of warfare called highly intense warfare, conventional. That is certainly anticipating more casualties than we would have in a high or low intensity type warfare.

Senator GLENN. Medically we are only half staffed to take care of that threat?

General BECKER. For an all-out war, for a big war. We are in fairly good shape for a small- or medium-size war. Big war, it is a big problem.

Senator GLENN. That is not much consolation.

Senator WILSON. Tell us why there are differences between the services in your estimating techniques.

General CHESNEY. The Air Force operates from fixed bases where we expect to take casualties. We do not plan to use our hospitals on our bases to a large extent in wartime because of their proximity to the targets.

The Army is mobile, thus the difference as to why our systems are priced differently. We have totally different plans, programs, problems that we have to work out.

Senator GLENN. Let me ask one other thing.

It seems to me we are not taking into account the one ace in the hole that we have left if we are in tough combat and hospitals are being knocked out which is the flexibility to shuffle people from one spot to another hospital. If the Army has three hospitals knocked out, you go to the Air Force hospital, and so on.

Yet we are told we can't even adequately communicate with each other.

Is there a real problem and how flexible are we in a combat situation?

Do people automatically know they can start shuffling people to this alternate, that alternate? Do you have a first choice alternate, a second choice where you are going to have people?

Is that all explained and a net set up to exercise? Have we practiced that?

If we are not planning for NBC warfare and we start having a big area of super activity and everybody is dead and we are having to shuffle people to completely different areas, that is our only recourse in a situation like that.

General BECKER. There is a very good net, both land line and radio. That is for the Joint Medical Regulating Organization who regulates all the casualties regardless of service and they are sent up to any hospital regardless of service.

Senator GLENN. By command, EUCOM, PAC, and so on?

General BECKER. Yes, sir. It is EUCOM Joint Medical Regulating Office. It has been practiced many, many times and does fine.

Senator WILSON. Let me ask one final question that is parallel.

In terms of trying to estimate wartime manpower requirements the services are using different methods to estimate the manpower required to perform a given war plan.

For example, for 1,000 hospital beds in the United States the Army says it would require 106 physicians, the Air Force 166, and Navy 392.

Why?

Dr. MAYER. That is because the three services have established totally different systems for estimating such requirements and with different givens in the system.

We have recently begun officially cross-service use of a uniform manpower medical planning module as part of the joint operation and planning system from the Joint Chiefs. As we apply that system across the services, most of the discrepancies will be ironed out, but with the result of totally different ways of reaching conclusions about manpower.

This has been recognized for some time as a significant problem. That is why we have begun the new process which should eliminate that problem.

Senator WILSON. I am prepared to entertain a motion, Senator Glenn, that the subcommittee go into closed session for the sole purpose of receiving and discussing information classified in the interest of national security.

Senator GLENN. I so move.

Senator WILSON. Mr. Tucker, will you ascertain that the room has been cleared of all those personnel except those with proper clearance who have need to be present.

[Whereupon, at 12:02 p.m., the subcommittee proceeded in an executive session.]

EXECUTIVE SESSION

Senator WILSON. Mr. Tucker, has the room been cleared of all personnel except those who have the proper clearance and need to be present?

Mr. TUCKER. To my knowledge, the front portion of the room is clear.

Mr. Pitkin, is the room in the back cleared?

Mr. PITKIN. It is.

Senator WILSON. Senator Glenn?

Senator GLENN. Thank you, Mr. Chairman. I appreciate it.

WARTIME CAPABILITY

General Toner, can you explain what the wartime capability is that is required of each service in the defense guidance?

What is the evacuation policy?

General TONER. Sir, the current and last several defense guidances prescribed that the services program for [deleted]. That is essentially it.

ZIMBLE REPORT

Senator GLENN. The Zimble report is quite clear. It concluded: "There is no effective command and control of medical planning or medical resources in USEUCOM."

Do you agree with that?

General TONER. No, sir, I don't agree with that. I believe there is effective medical planning going on in USEUCOM now and was even at the time of that report. It certainly has improved immensely since the report took place by the addition of personnel to that command and, obviously, additional command emphasis.

It certainly needed to be improved, but it certainly did exist. I would not agree with that comment.

Senator GLENN. General Becker, you were the EUCOM surgeon before you became Surgeon General of the Army.

Is the statement in the Zimble report that: "The USEUCOM surgeon has no directive authority over the service components' medical department in this peacetime."

Is that an accurate statement?

General BECKER. No directive authority on his own, that is correct. He has only directive authority through the Commander, USEUCOM.

Senator GLENN. That would be the same in wartime, I presume?

General BECKER. In wartime I am not sure exactly what the classified plan says, but I believe he obtains certain directive authority over the movement of patients. That is through, as I talked about a minute ago, the JMRO, the Joint Medical Regulating Office, has authority to make decisions about where patients will go and what priorities they will have.

I will have to provide that for the record. It is probably classified—maybe it is not classified, but it is in a EUCOM directive that I don't have here.

[The information follows:]

The USEUCOM Surgeon, has operational control of the USEUCOM Joint Medical Regulating Office. In this regard, based on the theater evacuation policy and information on hospital capabilities and capacities provided by service components, the USEUCOM Surgeon through the USEUCOMJMRO has directive authority over the movement of patients within the theatre.

The above is the only specified directive authority granted the USEUCOM Surgeon. Other authority, such as the prioritization of medical logistical requirements, are the prerogative of the USEUCOM Commander and could be so delegated to the USEUCOM Surgeon.

EUCOM CONTROL

Senator GLENN. Do you think EUCOM should have more direct control of the medical programs of the different services?

General BECKER. Yes, I do; I don't think he should have full-time directive control over the services, both in peace and war, but certainly in wartime, certain parts, he should be given certain very specific authority to control the medical supplies, the prioritization of where they would go, prioritization in evacuation of patients and

where they should be hospitalized, and to be able to defer them and use all the medical assets he has.

CROSS-SERVICE SHARING

Senator GLENN. General Chesney, the Zimble report noted the [deleted]. The Zimble report says that the Air Force has made no arrangement with the Army either for use of Army medical facilities in the early stages of the war or to make surplus capacity available to the Army later on.

Is that an accurate statement?

General CHESNEY. The Air Force [deleted].

If you look at the [deleted] or so of war, the Army casualties build up slowly relative to ours, but they have so many more in numbers than we do that it has not really been that appropriate for us to run to them for beds There will still be bed shortages in the Army.

We have discussed this. We have meetings every 2 months in Europe between the commanders who work these joint planning programs. There is no question but that there is every adequate daily planning going on between the lower echelons and monthly planning going on between the higher leaders in Europe today.

Senator GLENN. In the different services?

General CHESNEY. All the services. The different service chiefs meet every 2 months in Europe today and sit there talking plans and beds and that sort of thing.

General BECKER. Two of the culprits are here. This General and I were over there together before I left and he became the EUCOM surgeon. We met on regular occasions.

We overlaid our plans to see where we had facilities that we would both use and we agreed that that would be possible.

Also, after their peak casualty load early on that you spoke about, they would have beds and that is the plan that we would use those beds.

It is well known by all of us that no serviceman, no matter what his service, will be sent to any hospital just because it belongs to that service. All the hospitals will be for all of the people. I don't think there is any problem.

COMBAT ZONE HOSPITALS

Senator GLENN. General Chesney, according to the so-called Zimble report, I quote:

> By classifying many of the hospitals as combat zone facilities, the Air Force has effectively denied other services access to them.

General CHESNEY. We didn't do that on purpose. If we think they are in a combat zone, that is, they are going to be short at, we classified them that way.

Senator GLENN. If you classify them that way, it means the people from other services will be shunted somewhere else rather than to an Air Force hospital.

General CHESNEY. No, sir; the flow will be backward.

Senator GLENN. If you designate them as combat zone facilities, what different way are they going to operate than any other hospital?

General CHESNEY. Medically, not that much really.

Senator GLENN. What is the difference?

General CHESNEY. The combat zone and communications zone is an Army term which we have begun to use recently.

Senator GLENN. Have you classified some of your hospitals as combat-zone facilities?

Why did you classify them that way and how would they differ in use in wartime?

General GREENDYKE. Combat-zone hospital, by your terminology, would be those adjacent to an air base, either on the base or 5 miles off to keep them in a safe zone.

Senator GLENN. That puts them in a combat zone.

How are they used differently?

General GREENDYKE. They are used to give immediate care to patients, to start IV's and to give oxygen and get those patients ready for transport to places where definitive care will be done which is in the rear, communications zone in the terminology of the Army.

So, in practical terms, there are no beds in the Air Force near the Army's combat zone because we are going to move those patients within hours after stabilizing them.

Senator GLENN. I do not see why you have not designated them. There must be some reason why you have not designated them.

What is the reason?

General BECKER. It was not to deny the Army use because we have Army troops very near those air bases. It was well understood we would use those facilities if we had to and they would use ours. I don't know where that came from.

Senator GLENN. I don't understand the difference yet. Evidently there are different designations of hospitals or they would not have the separate designations set out here.

If you have classified them in some combat-zone facility, that is for some purpose.

What is the purpose?

General BECKER. We classify ours in the combat zone so that we will know which ones are under the division commander's guidance and the corps commander's. They are in his zone.

Senator GLENN. Let me read this again.

By classifying many of the hospitals as combat-zone facilities, the Air Force has effectively denied the other services access to them.

Is that accurate?

General CHESNEY. No, sir; it is inaccurate.

General BECKER. Maybe somebody back here is counting beds for the services and says combat zones belong to the services. I guarantee that is not true.

Senator GLENN. We have talked about [deleted].

General CHESNEY. May I explain the [deleted] problem? I think that was also an intelligence problem.

The Air Force intelligence felt that [deleted]. The Army tells us [deleted].

Early on we decided we would pull back because our intelligence people said we would be overrun. The Army was brave and they said they could defend [deleted].

General BECKER. [deleted] is a very strange place because it is now a [deleted]. It has changed. It used to be a [deleted].

THREAT ANALYSIS

Senator GLENN. I asked whether you are all operating on the same threat analysis. If you are, then I don't see how the Air Force and Army are coming up with different estimates of what is viable to keep and what is not.

It is not bravado. Somebody has to have an actual threat analysis of what the Soviets can do coming in. We all have to operate with the same music. We are not singing the same song.

General BECKER. You are absolutely right. You have found a place where we have fouled up. Overall we use the same threat analysis.

When we look at little places like that, we might have different threat analysis than our planners were looking at. This thing popped up one day out of the woodwork. Somebody said "Hey, the [deleted] is going to leave it." We did not even know why because it is so highly classified about the threat.

My planner said, "Can we use it?"

They said, "Sure, we are going to leave it. You can use it."

When these fellows came over and investigated, they came up with this humbug here. We ran it down to what was the truth. We put in a request to EUCOM for the intelligence analysis of that area by the Defense Intelligence Agency, all the way back, out of service.

They came back and said, "It is safe enough to stay," and the Air Force said, "We are staying in our hospital and the thing is finished."

As you say, it is not a giant gap in cooperation between the services.

EVACUATION OF CASUALTIES

Senator GLENN. General Toner, the Zimble report noted the [deleted].

Is that an important contradiction to be resolved and has it been resolved?

General TONER. I really cannot tell you whether it has been resolved at this time. I don't think it makes a lot of difference because the evacuation of the casualties will depend on what the situation is at the given time, whether or not the airstream that flows to Europe can in fact unload passengers and take them back to the United States. [Deleted.]

Senator GLENN. I know things like this would change in a combat situation. It seems to me you are tying up a lot of rolling stock for a long period of time when you are evacuating to the States.

You are going to be able to take care of fewer people overall with existing equipment than you would if you are [deleted] back and forth.

Now, the overall threat situation may include those countries so you may have to evacuate to the States, I do not know. Obviously, you need some flexibility. You need some contingency planning.

General BECKER. I have had much more detailed involvement in it than Frank has.

The Air Force and the Army have contingency hospitals in England. They have one that is sitting over there [deleted].

[Deleted]. You can walk in, turn the key, put the doctors and nurses in there, uncover the beds and you are OK.

It is ludicrous to think we are going to evacuate everybody from Europe to the United States. Where that came from, I do not know. The plans are [deleted].

Senator GLENN. I appreciate very much your being frank and open with us this morning. Obviously, we are very concerned about this as are a lot of people.

CLASSIFICATION OF REPORT

I would hope that when you go back you will consider whether these reports cannot be made open reports without the classification. I read through all these things. I didn't see much in there that I thought was really classified that much.

I had some of the same concerns that Senator Kennedy had when I read through them, that maybe we were covering some of our tracks as much as we were covering really classified information.

I hope maybe you can go back and take that word back from one who has read this thing and see if they cannot reconsider this thing because I think they will dribble out anyway.

If you can make a clean break of this thing and go on from here, I think it is probably the thing to do.

COMMUNICATIONS WITH COMMITTEE

One other thing. We are being critical in some of these areas, but we are trying to work to the same end. This is the Manpower Subcommittee here. What the chairman does and what I as ranking member do here may have a lot of influence on how we deal with some of your problems you are grappling with every day, how we get these men, how we keep them in, and so on.

We want to see this run as well as we possibly can run it and help you to do your job, too. That is what we are here for.

If you have suggestions for us on what we can do, the chairman and I and the committee would welcome a letter, call or conversations back and forth, to help us help you to make this a safer world.

It is not going to be a very safe world out there if we get into World War III.

If we can help you, I would like to know.

Dr. MAYER. Thank you, Senator.

ARMY/AIR FORCE COORDINATION

Senator WILSON. Senator Glenn asked two of the questions that I had intended to ask which had to do with EUCOM. Let me just take a point of departure.

What concerns me is that the Army and Air Force have been operating in Europe as a single Unified Command since at least 1956, almost 30 years, and in one way it is encouraging to learn that classification and security are that good, the Army does not know what the Air Force is doing in that particular hospital.

On the other hand, it seems somebody should know and not just Army doctors.

What are the Joint Chiefs of Staff doing to review this kind of situation, General Toner?

Senator Glenn asked another question that I had with respect to the air evacuation and the different plans of the Army and the Air Force to stage evacuees to different areas, in one case direct evacuation to CONUS. But another thing that is really an overall conclusion of which both Senator Glenn's questions indicate specific instances is the point made by the Zimble report that the service components have no plans for joint use of their medical facilities in wartime. I have heard you express to the contrary.

It does say that among other things needed in the discussion of the shortfalls, each of the services states:

> Acute wartime shortages are surgeons and supply of personnel. Shortages would arise at different times, they could be partially alleviated through cross service sharing of personnel.
>
> Despite the effective EUCOM referral system that improves peacetime quality of care and demonstrates the possibility of wartime recourse sharing, the services have as yet developed no plans for wartime sharing.

General TONER. When you are talking about wartime sharing, are you talking about logistical support or facilities?

Senator WILSON. I am talking about critical surgical specialties, but actually the question is broader than that. It is not just sharing of surgeons, it is sharing of facilities, everything that is involved in providing combat care.

General TONER. I think that in Europe in particular there are plans to use the hospitals of other services and that is the whole intent of the Joint Medical Regulation Operation that exists in Europe.

It is to take casualties and refer them to the hospital that has the bed available, the best type capability to handle a given type of injury regardless of service. That is an existing operational entity today and capable of going to war.

With respect to the logistical resources, I think EUCOM at the present time is conducting a study to see how much of that sort of thing can be done, the shifting of resources from one service to the other.

We expect to hear by the first of the year on what EUCOM's use of that particular issue is. I think there is an awful lot more planning between the services and coordination at the EUCOM level than this particular report gives us credit for.

Dr. MAYER. This report is 20 months old and a great deal of progress has been made since that time.

Senator WILSON. Dr. Mayer, in your judgment, when it was rendered 20 months ago, was the Zimble report accurate?

Dr. MAYER. Yes, sir, it was embarrasing to some elements. There were a lot of assumptions that there was sharing going on that was not going on.

The imperative for it did not seem to be present until, unfortunately, we were faced with a situation which showed there were cracks, some big ones, that needed to be plugged.

As I said, the services have moved out smartly to plug those cracks and to do joint planning.

LIVE EXERCISES

Senator WILSON. You have had live exercises since the Zimble report?

Dr. MAYER. Yes; Reforger was one instance. We did it in two phases. It was an opportunity to examine whether or not the joint sharing of information was beginning to work, and it was. It is not by any means perfect yet, but there are a lot of assumptions about how well it was going before the disaster in Beirut that proved not to be true.

So, yes, in my judgment, the Zimble report was a very accurate statement of the status quo at that time with respect to medical planning and medical sharing agreements in the European Command.

I don't say that in criticism of anybody. I can see how it evolved. It just could not be allowed to persist. Indeed, the services have made sure it won't persist.

Senator WILSON. Our purpose is not to hang anybody. We take no joy in pointing the finger, but the Zimble report and the PACOM report are genuinely alarming. The deficiencies they point out, if accurately stated, simply have to be corrected.

They relate to sharing of facilities, personnel, evacuation plans to the kind of joint planning that, very candidly, we should have been able to assume was going on 30 years ago and it clearly was not.

Let me ask you this. When I asked about live exercises, I assumed that almost all of the planning within the NATO theater anticipates a major offensive by Warsaw Pact nations.

Have there been any kind of live exercises with respect to some of the more obvious threats of terrorism?

General BECKER. Yes.

General CHESNEY. We have recently had a terrorist action in Greece, the same number of casualties occurred as occurred in Beirut. They were picked up, flown to the Air Force hospital—most of them were Navy men—and flown to the Army hospital.

You never heard of it. We have done it since then, the same size, the same number of casualties as in Beirut. There was no problem.

Senator WILSON. You are right. We have not heard about it.

General BECKER. There are other sensitive exercises that took place directly as a result of the Lebanon thing. They are with [deleted] where we have had joint exercises with them to take casualties into their hospitals by our helicopters and also [deleted] heli-

copters taking their patients off our ships, if I remember right. That went very well.

It is planned in detail. All of the complex procedures to get into [deleted] that is, communications procedures and clearance procedures, are now known by the people that operate in that area of the world.

So, that went extremely well.

ZIMBLE REPORT—ARMY COMMENT

I would like, if the opportunity arose, to make my comment on the Zimble report.

Senator WILSON. Now is your time.

General BECKER. I think that overall the Zimble report reported out deficiencies that needed to be fixed. I don't have any problem with that. I do not want you to think that I am saying otherwise.

But there were an awful lot of fine people over there working together for a long time that I would be remiss if I did not say something in their defense.

We worked very closely together and all plans over there are joint plans. [Deleted] is a joint plan of the JCS. Now, were those the greatest plans in the world? Maybe not. Had we a specific piece of paper that said we would share this surgeon and that surgeon, that is what that guy did not find.

I can tell you that the people over there were ready to do whatever was necessary to take care of the casualties. Now, that is an informal system, I know, and what we are talking about here is a formal one.

Senator WILSON. General, I accept that. I think no one questions the measures taken by the medical people involved. Truly heroic measures were taken.

What the Zimble report identifies is that to the extent they were successful, they seemed to be successful in spite of the lack of cross service plans.

General BECKER. For a disaster. One of the assumptions of the Zimble and Long Commissions was that this was a war. Now, this was a disaster in which those casualties were accumulated in an instant. That is a little different than a war, not much.

It gives us no excuse for not having a disaster plan. That is what we did not have. We had SOP's but we reacted to any disaster and call for help. That is what we did.

PACOM REPORT

Senator WILSON. Let me quote from the report on Pacific Command readiness:

> [Deleted] respectively.
> These shortfalls will, if allowed to persist, result in precipitant out-of-theater evacuation of lightly wounded, combat experienced and trained manpower which would otherwise be available for reassignment in theater. These lightly wounded personnel, if retained in theater, are literally the replacement system for the first few days of a conflict.
> The most significant result of a treatment capability shortfall will likely be the unnecessary death or permanent disability of many of our soldiers, sailors, marines, and airmen.

Let me ask whoever can answer this question.

What casualty rate of return to duty in theater is assumed in [deleted].

General TONER. [Deleted.]

Senator WILSON. Can you put that in percentage of casualties?

General TONER. I do not believe I can do that.

Senator WILSON. I am going to ask you to do that for the record. also, having done that, to answer this question for the record.

[The information follows:]

CASUALTY RATE OF RETURN

Senator WILSON. What casualty rate of return to duty in theater is assumed in [deleted] during the first ten days of conflict?

General TONER. The rate of return varies based upon the evacuation policy that is in effect. For example, if the evacuation policy is [deleted]. As the evacuation policy increases, the rate of return increases also. The same is true for the Communication Zone. In the Communication Zone, [deleted].

Senator WILSON. Also, having done that, to answer this question for the record.

Is that rate, whatever it turns out to be, is that rate of return to duty in the theater [deleted].

[The information follows:]

CASUALTY RATE OF RETURN

General TONER. [Deleted.]

Senator WILSON. Let me ask Dr. Mayer or General Toner. Maybe it is a question better addressed to you.

SHORTFALL IN PACOM

How long has the shortfall which is identified in this report existed in the Pacific Command?

General TONER. I would say, without having made a detailed analysis, that it has existed for a considerable period of time.

Dr. MAYER. I agree.

Admiral SEATON. Since the end of Vietnam.

Dr. MAYER. At least. The shortfall is identified and was put into plans. That is certainly how we began our plans for the hospital program.

Some of those fleet hospitals are assigned to Guam, Okinawa, and Korea and that is why it was so devastating to have the military construction for the one in Guam to be chopped recently.

Dr. MAYER. Not to mention the one in Korea. Unless we can put down a concrete hard stand so that we can put up a warehouse so that we can put in a 500-bed hospital set, we are going to go along having 140 beds in Korea with 40,000 or 50,000 American troops there.

Admiral SEATON. We can precisely define the shortfall. We can plan to correct the shortfall over a 5-year defense plan, but if the resources are not provided and allocated, we cannot correct it with actual hardware overseas.

General CHESNEY: We have the money in our budget. We are ready to do it, but the House has said we cannot build anything in Korea.

Admiral SEATON. Admiral Zimble got those numbers from plans that were indeed certifying those shortfalls.

Dr. MAYER. And we were supported all through by the JCS and the Defense Resource Board.

Senator WILSON. That is a question we will ask ourselves. We will find out why the House turned you down.

Gentlemen, we may have additional questions for you, but we are out of time.

MEDICAL EVACUATION

Let me ask this one question now.

Peacetime air medical evacuation system is designed to meet day-to-day requirements with insufficient provision for troop training and rapid expansion to wartime operation. If the six C-9 aircraft provided to EUCOM explicitly for the medical evacuation mission, three have been diverted for administrative transportation requirements and are unavailable for medical evacuee training missions.

Consequently, there are too few trained air medical evacuation crews to serve wartime requirements.

This is from the Zimble report.

General GREENDYKE. Sir, there are five C-9 aircraft in Europe and two are being used administratively. The three take care of peacetime requirements in the European theater.

We currently have the initiative at MAC that looks like it will get favorable consideration to use the remainder of the domestic fleet to augment in wartime the traffic flow in the theater.

That will take the load for air evacuation off the 130's which will be largely used by the line commanders. We feel we can reduce the need for 130 transportation in the theater 50 percent by using C-9's which are currently domestic.

Senator WILSON. That will give you how many C-9's in total?

General GREENDYKE. Eighteen.

Dr. MAYER. It is true, as Admiral Zimble stated, only three were available and dedicated to medical evacuation at that time 20 months ago. He said three because that was his understanding, but the other two were so-called administratively assigned.

General GREENDYKE. And can be returned to the fleet within hours because they can be reconfigured.

Senator WILSON. The point was made by Zimble which had to do with the absence of training, the fact that there are too few aircraft available to have adequately trained crews. It is a small number in any case.

General GREENDYKE. The crews are being trained in the domestic system on a day-to-day basis.

General CHESNEY. We have the air evacuation crews in the United States if we are given time to do it.

Senator WILSON. We will now go back into open session.

[Whereupon, at 12:42 p.m., the subcommittee proceeded in open session.]

OPEN SESSION

CLOSING REMARKS—SENATOR WILSON

Senator WILSON. We are back now in open session. Let me just make a brief closing comment.

I am grateful to all of you for being here today and some of my colleagues earlier expressed the thought that this has been one of

the more valuable hearings we have had. It is one of the most important subjects we have dealt with and I think the candor with which the deficiencies in the wartime medical readiness have been addressed this morning is commendable.

What is going to be more commendable is further correction of those deficiencies. We have heard some very disturbing testimony today, both in open and in closed session.

The Zimble report, and PACOM report are deeply disturbing. Our medical system, I think you would have to concede, is not ready to provide the medical care which the young men and women in the Armed Forces need and are entitled to receive in the event we become involved in a major conflict or as the victims in an act of terrorism.

We have seen a report on the medical readiness in the U.S. Pacific Command where a tremendous shortfall in medical capability exists in that command which in the words of the Department of Defense means:

> The most likely result of the increasing shortfall will be unnecessary deaths of people, disability of many of our soldiers, sailors, marines and airmen.

That is not acceptable. What you have told me today indicates that the dereliction is at least shared by the Congress.

I can believe after listening to you this morning, that that is not acceptable to any of the witnesses who have served on our panel. The fact that the shortfall exists means that the system as it is presently functioning is seriously inadequate.

I want to in particular applaud the efforts that Dr. Mayer has made to improve the system, improve the capability and to ensure the various parts of the military system can operate an integrated system and not as a separate independent system. That is the reason perhaps for what is affordable at another time is not now affordable either in terms of the dollar costs or the human costs involved, which are far more serious.

As I have indicated, I think that this is the larger problem. Our military medical system must change. I think that our entire system must change. We simply cannot afford the lack of communication or possibly rivalries that do not enhance our overall security or, in the case of our medical care, the quality of that care.

Our military medical system must be able to provide needed wartime medical care. I think with the cooperation from us, the kind of professionalism that we are pleased to see here, the kind of candor that we have met with this morning, make me feel confident that we can do so. But we are a long way from doing so.

So, we will spend a great deal of time together until we have made much greater strides to improve that system.

Thank you very much.

Dr. MAYER. Thank you.

[Questions submitted by the Senators of the Armed Services Manpower and Personnel Subcommittee to be answered for the record follow:]

QUESTIONS SUBMITTED BY SENATOR STROM THURMOND

WARTIME MEDICAL READINESS/SECRETARY OF DEFENSE

Senator THURMOND. Since the United States turned to an all volunteer force, there has been a large increase in the number of married service personnel followed by an increase in emphasis on family practice type medical care.

What impact has this had on wartime medical readiness?

Dr. MAYER. The reliance that we have traditionally placed on our Military Health Services System to accomplish two vast missions, wartime readiness and the enormous peacetime benefit mission to which you refer, has placed significant strains on our ability to accomplish either one effectively. The resources made available to us have never been adequately sufficient to meet two sets of substantially different demands on our system, and both wartime readiness and peacetime missions have suffered as a result. Pressed by a demand to provide comprehensive health care to some 10 million beneficiaries, of whom only 20 percent are active duty personnel, we have not been able to assure top priority to wartime readiness. Thus, our force structure does not meet our wartime requirements either in number or in mix. Our training programs do not adequately address wartime manpower priorities. Finally, our peacetime benefit mission presents a workload that is largely irrelevant to developing and maintaining specialty skills necessary for wartime readiness.

Senator THURMOND. Will this emphasis change in the future?

Dr. MAYER. Yes, it is our conviction that change is needed. We intend to change the expectation that the Military Health Care System, as we now know it, must accomplish both our wartime and peacetime missions. In this regard, we have begun to take the steps necessary to meet what I believe are the greatest challenges before us, to which I alluded previously: first, to sort out our wartime readiness mission and our peacetime benefit mission; second, to improve substantially our ability to utilize civilian health care resources to meet a larger portion of our peacetime benefit demand; and third, to accelerate the redirection of our military direct care system to achieve our top-priority commitment to medical readiness. Attaining and maintaining wartime medical readiness will be the guiding principle in determining the size and scope of our active duty and reserve forces, our training programs, our facilities and our in-house workload.

Senator THURMOND. What impact will this have on care for dependents and retired military personnel?

Dr. MAYER. The redirection of priorities for the military health care system toward wartime readiness will not cause a reduction in health benefits for dependents or retirees. We will not depart from our firm commitment to provide quality health care to dependents of our active duty forces and to retired members and their families. Dependents and retirees will still be treated in military hospitals as well as in civilian facilities, but the nature of the health services provided to them is likely to change. More family health services will be provided outside military hospitals, while more surgical care will be available in them. As a part of the renewed emphasis on wartime readiness, we are examining ways to make major improvements in the system for providing civilian health care services for our beneficiaries.

Senator THURMOND. What is our level of ability to care for personnel who have been exposed to chemical or nuclear weapons?

Dr. MAYER. We have a problem in this area that has been highlighted by the Medical Readiness Reviews of EUCOM and PACOM. As you are aware, our casualty predictions have been based on conventional warfare. This may not be realistic if we accept the degree of Soviet training in the use of chemical agents. Our hospitals are not hardened for survival in a chemical or nuclear environment. Our medical corpsmen receive some training and our physicians receive some instruction in the Combat Casualty Care Course, but it is simply not enough. I have encouraged the services to further develop their capability but it needs more of our attention.

WARTIME MEDICAL READINESS/ARMY

Senator THURMOND. General Becker, since the United States turned to an all volunteer force, there has been a large increase in the number of married service personnel followed by an increase in emphasis on family practice type medical care. What impact has this had on wartime medical readiness?

General BECKER. The emphasis on family practice has had a positive impact on medical readiness by providing the Army with a more highly-skilled physician force and enhancing the availability of critical wartime medical skills. Family practice authorizations have been obtained by converting previously-authorized general med-

ical officer positions to family practice positions. Family practice is a nationally-recognized medical specialty, and family practice physicians are more highly-trained than general medical officers, receiving training in a broad spectrum of medical specialties. In the event of mobilization, family practice physicians will be used in critically-short wartime physician specialties.

Senator THURMOND. Will this emphasis change in the future?

General BECKER. The Army's Family Practice Program began in 1972. We now have 240 family practice physicians on active duty and plan to increase this number to 878 by 1992. As in the past, this increase will be achieved primarily by converting currently-authorized general medical officer positions to family practice positions.

Senator THURMOND. What impact will this have on care for dependents and retired military personnel?

General BECKER. The increase in family practice will not only enhance medical readiness but also enhance our ability to meet peacetime health care obligations. Family practice type medicine is well received and very popular with our soldiers, both active duty and retired, and with their families. My eventual goal is to be able to assign a physician to each military family. The increase in family practice physicians will help meet this goal, insure that military families receive primary health care from highly-trained physicians, and increase patient satisfaction with the military health care system. Dependents and retired military personnel will be direct beneficiaries of this enhanced medical capability.

WARTIME MEDICAL READINESS/OJCS

Senator THURMOND. Since the United States turned to an all volunteer force, there has been a large increase in the number of married service personnel followed by an increase in emphasis on family practice type medical care. What impact has this had on wartime medical readiness?

General TONER. Sir, from a joint perspective, I'm sure that there has been little impact on medical readiness. The services have replaced some of their general medical officers (GMOs) with family practice physicians. Those family practice physicians are trained in basic triage, resuscitation, burn management, and basic surgery. These physicians would be useful in either the combat zone hospital or the communication zone facilities should they be assigned to the theater of operation. Physicians remaining in CONUS will be used to treat returning casualties or provide dependent care in those military hospitals so designated.

Senator THURMOND. Will this emphasis change in the future?

General TONER. Again sir, our perspective from the joint arena is such that we do not see any dramatic changes for family practitioners.

Senator THURMOND. What impact will this have on care for dependents and retired military personnel?

General TONER. I'm sure the services have a better feel for this than I do, however, it's my understanding that dependents and retired military personnel will continue to receive care through DOD sources but with greater emphasis being placed on alternative programs in the future.

Senator THURMOND. What is our level of ability to care for personnel who have been exposed to chemical or nuclear weapons?

General TONER. Sir, at this time our ability to care for chemical/nuclear casualties [deleted].

WARTIME MEDICAL READINESS/NAVY

Senator THURMOND. Since the United States turned to an all volunteer force, there has been a large increase in the number of married service personnel followed by an increase in emphasis on family practice type medical care. What impact has this had on wartime medical readiness?

Admiral SEATON. The increased emphasis on family practice medical care began in 1972 when the Navy's family practice residency program started preparing physicians to replace "general medical officers." This multi-faceted program provides the Navy with a fully trained specialist for a diverse contingency role. This training includes triage, resuscitation/stabilization, surgery, pre- and post-operative patient management, intensive care, management of burns, psychiatric disorders, fractures, wound debridement, etc. These versatile practitioners have improved our wartime medical readiness.

Senator THURMOND. Will this emphasis change in the future?

Admiral SEATON. We are gradually coding more readiness billets as family practice. These are not additional requirements but upgrade existing primary care medical officer billets.

Senator THURMOND. What impact will this have on care for dependents and retired military personnel?

Admiral SEATON. It will upgrade the capability for peacetime care to dependents and retired personnel by having it delivered by practitioners who have received more comprehensive training in general medical care.

Senator THURMOND. What is our level of ability to care for personnel who have been exposed to chemical or nuclear weapons?

Admiral SEATON. [Deleted]. Qualitative and quantitative medical support requirements are based on casualty estimates derived from conventional injury projections. Because it is difficult to anticipate how chemical or radiobiological agents may be delivered, which agents may be used, and which populations may be targeted, we must necessarily put a heavy emphasis on early detection and the extensive use of personal protective equipment (masks, overgarments, boots, gloves) and known and available antidotes (atropine and pralidoxime chloride). The thrust of our emphasis is training at the Field Medical Service Schools, shipboard training programs, unit training programs (USMC), the combat casualty care course, and other command sponsored training.

Optimally irradiated and chemically contaminated casualties should be decontaminated and cared for in a clean, protected environment. The Navy and Navy Medical Department has initiated a number of developmental efforts to attempt near and far term solutions. In conjunction with the Army and Air Force, we are looking at collective protection systems which might be utilized as close as possible to the battle area. Collective protection systems are being installed on LHA class ships. Mobile patient decontamination systems which have applicability both ashore and afloat are under development at the Naval Surface Weapons Center, Dahlgren. We are investigating alternative approaches to collectively protect Fleet Hospital components, particularly those to be prepositioned in the combat zone. We are also looking at techniques and procedures for "hardening" our field facilities and ships against chemical and radiobiological exposures. There are improvements in certain casualty equipment which will allow for patient monitoring while in a protective posture, and there is as well the impending procurement of casualty wraps which will protect the non-ambulatory casualty during transport through a contaminated environment.

We are continually reviewing concepts of operations and updating our techniques and procedures to maintain relevancy and currency to both research and development and operational requirements.

WARTIME MEDICAL READINESS/AIR FORCE

Senator THURMOND. Since the United States turned to an all volunteer force, there has been a large increase in the number of married service personnel followed by an increase in emphasis on family practice type medical care. What impact has this had on wartime medical readiness?

General CHESNEY. The emphasis on trained and board certified physicians in the specialty of family practice has had a very positive impact on medical readiness. These physicians have a wide background in medical/surgical training. They have experience handling trauma, including wounds, broken bones, and triage and their skills are easily adapted for wartime.

Senator THURMOND. Will this emphasis change in the future?

General CHESNEY. No. I don't foresee the emphasis on family practice changing much at all.

Senator THURMOND. What impact will this have on care for dependents and retired military personnel.

General CHESNEY. The military health care system offers a wide range of health care services for active duty dependents and retired personnel. Retention studies cite medical care for themselves and family members as a leading incentive for continued active duty service. Other studies cite continuity of care as being highly desirable. The family practice concept has allowed the Air Force to make great advances in this area. This solid medical system, comprehensive in peacetime, is easily adapted for wartime and our members serve confidently knowing this. The emphasis on family practice serves DOD and the Air Force very well. Treating and managing the illness and injuries of dependents and retired military personnel on a day to day basis in peacetime maintains the physician's skills for application in wartime.

Senator THURMOND. What is our level of ability to care for personnel who have been exposed to chemical or nuclear weapons?

General CHESNEY. [Deleted.] To enhance one treatment capability, beginning in the Dec 85 timeframe we will field pyridostigmine, to be used as a pretreatment

drug, which will enhance therapeutic treatment of chemical warfare (CW) casualties. In addition, we are working extensively with the Army Medical Research and Development Command to develop improved CW antidotes, medical treatment methods and defensive systems such as collective protection and decontamination. For nuclear weapons effects, we are capable of treating resulting blast and thermal injuries but there is no known cure for high level radiation exposure (acute radiation syndrome). [Deleted].

Questions Submitted by Senator James Exon

CASUALTY PREDICTIONS/SECRETARY OF DEFENSE

Senator Exon. How accurate were our casualty predictions in World War II, the Korean War, and the Vietnam War?

Did we tend to overestimate or underestimate anticipated casualties?

Dr. Mayer. Research indicates that casualty predictions in each of these wars were a rather inexact science and that casualty predictions were probably underestimated more often than not.

Senator Exon. How did our actual medical capabilities prior to World War II, Korea and Vietnam compare to our estimate of casualties?

Dr. Mayer. Our capabilities prior to World War II, Korea, and Vietnam were woefully inadequate to meet the requirements. In deference to the planners of those times, it should be recognized that Korea was an unanticipated surprise attack and although we had a period of mobilization prior to World War II, no one predicted the enormity of that war. Vietnam escalated over a period of many years. In each instance we had the time to build a medical structure to support the Armed Forces; for example, during World War II the Army expanded from 12,370 beds in 1939 to almost 600,000 fixed beds and 86,000 mobile beds in 1945. We paid a price for our lack of adequate support in the early days of each war, however, because patients were evacuated out of theaters that, had adequate support been available, could have been treated in theaters and returned to duty within a few days. This generated requirements for a replacement, his transportation to theater, and the transportation of the patient back to another area where medical care was available—generally the Continental United States.

I should point out that the medical departments do not develop casualty predictions. This is primarily the job of the personnel and manpower planners. Currently, each of the services uses computer-assisted models based on United States military experience as well as some input from more recent wars such as the Arab-Israeli War of 1973. The services' medical departments do estimate the expected hospital admissions from disease and non-battle injuries.

Senator Exon. If we underestimated our casualties, by how much were we off in each of the above wars?

Dr. Mayer. Data are not available to show by how much or over what period of time casualties were underestimated.

CASUALTY PREDICTIONS/OJCS

Senator Exon. How accurate were our casualty predictions in WWII, the Korean War, and the Vietnam War? Did we tend to overestimate or underestimate anticipated casualties?

General Toner. Sir, we have tried to research this information and have not been successful. We cannot find any information regarding predictions prior to these wars.

Senator Exon. How did our actual medical capabilities prior to WWII, Korea, and Vietnam compare to our estimate of casualties?

General Toner. We have not found any figures for comparison. We do know, for example, that the Army Medical Department was limited in size during that early period.

Senator Exon. If we underestimated our casualties, by how much were we off in each of the above wars?

General Toner. Without figures to compare, we cannot provide an answer. Our research showed only actual experiences from those wars, no predictions prior to them.

CASUALTY PREDICTIONS/ARMY

Senator EXON. How accurate were our casualty predictions in World War II, the Korean War, and the Vietnam War? Did we tend to overestimate or underestimate anticipated casualties?

General BECKER. Estimated casualty rates made prior to World War II, Korea, or Vietnam are not available. It appears that bed requirements for these wars were generated on the percentage of the population at risk which were in turn based on the expected Disease Non-Battle Injury (DNBI) and Wounded In Action (WIA) rates. The resultant bed requirements were further adjusted based on recovery times and theater evacuation policy. Since estimated casualty figures are not available I cannot comment on whether they were overestimated or underestimated when compared to actual casualties.

Senator EXON. How did our actual medical capabilities prior to World War II, Korea and Vietnam compare to our estimate of casualties?

General BECKER. Since it is unknown what, if any, rates were used for casualty estimates prior to the wars in question, it is impossible to state how our capability compared. It is reasonable to assume that prior to World War II, Korea and Vietnam, the Army Medical Department, like the rest of the Army was relatively unprepared and had to depend upon the mobilization industrial base and civilian populus to upgrade our capability.

CASUALTY PREDICTIONS/NAVY

Senator EXON. How accurate were our casualty predictions in World War II, the Korean War, and the Vietnam War?

Admiral SEATON. I do not know of a system to determine casualty rates for medical planning in peacetime prior to the mid-1970's.

Senator EXON. How did our actual medical capabilities prior to World War II, Korea, and Vietnam compare to our estimate of casualties? Did we tend to overestimate or underestimate anticipated casualties. If we underestimated our casualties, how much were we off in each of the above wars?

Admiral SEATON. As it is unknown if casualty estimating rates existed prior to these wars, it is unknown how medical capabilities compared to these rates. The Navy relied heavily on the draft to provide health care personnel to upgrade our capabilities in wartime.

CASUALTY PREDICTIONS/AIR FORCE

Senator EXON. How accurate were our casualty predictions in World War II, the Korean War, and the Vietnam War? Did we tend to overestimate or underestimate anticipated casualties?

General CHESNEY. If casualty predictions were made, military medical requirements appear to have been underestimated. We have found no evidence that a planner has ever successfully estimated the magnitude of the medical catastrophe, which was about to occur, prior to the onset of a war. We have experienced medical deficiencies in all past wars, and these have been very well documented since the Napoleonic Campaigns. We have retrospectively studied the great improvements in wartime medical care by reviewing the mortality and morbidity statistics of past conflicts.

Senator EXON. How did our actual medical capabilities prior to World War II, Korea and Vietnam compare to our estimate of casualties.

General CHESNEY. We know that during the time of the Normandy invasion sufficient U.S. general hospitals were not available to care for our wounded. The Army Air Corps went from a strength of 51,165 in 1940 to 2,372,292 by 1944. We relied heavily on our allies for support until we rapidly expanded our hospital system to full operational capability. Medical care capability markedly improved in Korea with helicopters used as medical evacuation vehicles. In Vietnam, transportation time from the site of injury to professional medical care was reduced to a matter of minutes. During WWI the overall mortality rate was 8.5 percent of those who served; WWII saw the rate fall to 5.8 percent. In Korea, the mortality rate was further reduced to 2.4 percent and in Vietnam this rate was again reduced to 1.7 percent.

Senator EXON. If we underestimated our casualties, by how much were we off in each of the above wars?

General CHESNEY. Since we could not find any prospective rates, we do not know if predictions of casualties were overestimated or underestimated. However, through the evolution of modern technology we are developing computer simulations that we

believe will allow us to predict prospectively and with a certain degree of accuracy casualty rates that we might experience in future wartime scenarios.

Questions Submitted by Senator John Glenn

MANPOWER/ARMY

Senator Glenn. Army Surgeon General, please provide for the record your total fiscal year 1986 wartime requirement, both active and reserve, for medical personnel. Include the number of physicians by specialty, the number of nurses by specialty and the number of enlisted medical personnel by specialty. Also indicate your fiscal year 1986 projected supply, both active and reserve, for each specialty of medical personnel.

General Becker. The information is as follows: Note that current inventory is provided rather than projected fiscal year 1986 inventory. Significant changes in current inventory is not expected during fiscal year 1986. Show rates are not applied to the Reserve component strength figures and skill substitution has not been applied to crosslevel any shortages.

SSI and title	Peak mob req. all compo	Total assets avail (gross)	Percent fill to mo-breq.	Active assets	ARNG assets	USAR tpu. assets	Irr. assets	Ima. assets	Retiree assets (category I and II)
MEDICAL CORPS									
60A—Operational medicine	719	308	43	0	129	145	7	0	27
60B—Nuclear medicine	43	48	112	36	1	5	3	1	2
60C—Prev. medicine	256	155	61	64	19	37	9	5	21
60D—Occpat. medicine	15	4	27	4	0	0	0	0	0
60E—Gen. medicine	2,287	2,335	102	1,105	235	552	400	4	39
60F—PULMON medicine	121	42	35	20	0	7	8	0	7
60G—Gastro	145	62	43	31	0	21	7	2	1
60H—Cardiology	205	98	48	37	0	23	21	0	17
60J—Ob/gyn	253	508	201	308	6	55	98	1	40
60K—Urology	214	154	72	65	6	47	20	0	16
60L—Derm	155	130	84	70	0	26	17	1	16
60M—Allergy/imm	86	34	40	19	0	7	6	0	2
60N—Anesthesiolgy	494	284	57	143	8	74	47	2	10
60P—Pediatrics	11	595	5,409	417	0	62	92	4	20
60Q—Ped. cardiology	1	12	1,200	9	0	1	1	1	0
60R—Child neuro	11	7	64	7	0	0	0	0	0
60S—Opthalmology	219	179	82	84	4	43	33	0	15
60T—Otolaryngology	222	140	63	66	3	39	20	2	10
60U—Child psychiatry	11	32	291	24	0	1	4	0	3
60V—Neurology	152	107	70	61	0	20	16	2	8
60W—Psychiatry	495	442	89	218	9	122	66	6	21
60Z/61B—Hematology/oncology	29	43	148	29	0	1	8	3	2
61A—Nephrology	44	26	59	16	0	1	9	0	0
61C—Endocrinology	36	36	100	25	0	2	6	0	3
61D—Rheumatology	2	10	500	10	0	0	0	0	0
61E—Clinical pharmacy	6	2	33	0	1	0	1	0	0
61F—Internal medicine	1,621	1,437	89	779	76	340	174	9	59
61G—Infectious disease	45	25	56	22	0	1	2	0	0
61H—Family practice	70	635	907	472	2	34	115	5	7
61J—General surgery	1,823	1,272	70	423	184	445	166	10	44
61K—Thoracic surgery	204	105	51	29	10	28	16	3	19
61L—Plastic surgery	617	44	7	16	0	5	12	2	9
61M—Orthopedic surgery	1,098	448	41	152	35	152	67	6	36
61N—Aviation medicine	254	230	91	118	50	3	41	1	17
61P—Physical medicine	56	60	107	27	0	21	9	1	2
61Q—Therapeutic rad.	1	21	2,100	13	0	3	5	0	0
61R—Diagnostic rad.	262	219	84	166	1	5	40	3	4
61S—Radiology	228	141	62	6	11	83	29	1	11
61T—Anatomic path	10	19	190	12	0	3	3	0	1
61U—Pathology	342	384	112	194	4	81	66	9	30
61V—Clinical path	6	7	117	4	0	0	2	1	0

SSI and title	Peak mob req. all compo	Total assets avail (gross)	Percent fill to mob req	Active assets	ARNG assets	USAR tpu assets	Irr assets	Ima assets	Retiree assets (category I and II)
61W—P. VSC surgery	22	6	27	1	0	1	2	0	2
61Z—Neurosurgery	163	72	44	19	2	22	19	4	6
62A—Emergency medicine	649	123	19	88	13	11	9	0	2
Total	13,703	11,041	81	5,409	809	2,529	1,676	89	529
ARMY NURSE CORPS									
66A—Nurse admin	649	444	68	111	74	168	11	4	76
66B—Commun hlth	210	267	127	142	13	20	58	7	27
66C—Psych/mh	686	501	73	157	9	154	135	6	40
66D—Pediatrics	44	518	1,177	307	0	40	147	7	17
66E—Oper room	2,012	1,170	58	335	117	495	155	5	63
66F—Annesthesia	1,730	774	45	245	64	241	91	3	130
66G—Ob/gyn	111	419	3,77	228	0	50	120	2	19
66H—Med. surg	14,246	7,210	51	2,006	622	2,785	1,485	45	267
66J—Clinical	3,427	2,256	66	692	34	1,217	304	1	8
Total	23,115	13,559	59	4,223	933	5,170	2,506	80	647
ENLISTED MEDICAL CORPSMEN									
91A—Medical specialist	36,924	40,165	109	14,674	9,384	7,999	8,104	0	4
91B—Medical NCO	14,812	17,046	115	4,390	4,260	2,919	895	0	4,582
91C—Practical nurse	20,138	9,067	45	3,117	1,021	2,395	486	0	2,048
91D—Or. specialist	6,553	5,127	78	1,427	572	2,080	659	0	389
91E—Dental specialist	4,980	4,791	96	1,883	351	1,434	666	0	457
91F—Psych specialist	1,299	856	66	335	9	265	129	0	118
91G—Behavioral science	1,613	1,616	100	892	102	326	160	0	136
91H—Orthopedic	1,081	683	63	267	54	221	57	0	84
91J—Physical therapy	930	601	65	242	0	282	43	0	34
91L—Occupational therapy	460	249	54	98	1	108	29	0	13
91N—Cardiac specialist	340	295	87	166	8	65	30	0	26
91P—X-ray specialist	3,328	2,668	80	1,021	245	879	319	0	204
91Q—Pharmacy specialist	3,012	1,678	56	793	171	496	162	0	56
91R—Vet. food inspector	1,606	1,821	113	1,113	29	147	147	0	385
91S—Environmental health	1,498	1,302	87	632	110	285	120	0	155
91T—Animal care	575	637	111	482	1	55	75	0	24
91U—Ent. specialist	401	300	75	156	4	69	40	0	31
91V—Respiratory	1,438	358	25	198	31	89	24	0	16
91W—Nuclear medicine	88	89	101	66	0	0	10	0	13
91X—Health physics	45	143	318	35	1	0	1	0	106
91Y—Eye specialists	567	405	71	286	10	25	71	0	13
92B—Laboratory	7,075	5,576	79	1,769	474	2,137	806	0	390
92E—Cytology specialist	81	43	53	41	1	0	0	0	1
94F—Food service	3,873	2,944	76	681	198	1,289	402	0	374
35G—Biomedical equip. B	528	455	86	241	44	156	0	0	14
35U—Biomedical equip. A	1,117	973	87	440	81	220	41	0	191
42C—Orthodic specialist	241	166	69	80	.....	21	11	0	54
42D—Dental laboratory	1,013	1,135	112	444	40	307	137	0	207
42E—Optical laboratory	521	350	67	174	13	44	42	0	77
71G—Patient admin	4,881	4,387	90	1,389	536	1,469	680	0	313
76J—Medical supply	5,677	4,746	84	1,651	498	1,560	546	0	491
01H—Biological sciences	217	285	131	212	0	2	71	0	.....
Total	126,912	110,957	87	39,395	18,249	27,344	14,963	0	11,006

MANPOWER/NAVY

Senator GLENN. Please provide for the record your total fiscal year 1986 wartime requirement, both active and reserve, for medical personnel. Include the number of physicians by specialty, the number of nurses by specialty, and the number of enlisted personnel, by specialty.

Admiral SEATON. This list contains the fiscal year 1986 predicted unconstrained wartime requirements for physicians, nurses, and enlisted personnel, by specialty. The predicted requirements are broken out by deployable naval systems and the Continental United States (CONUS) requirements. The requirements are based on [deleted] scenario developed in accordance with Defense Guidance [deleted].

NOBC	Deploy systems ACDU/RES	CONUS ACDU/RES
1. Medical Corps requirements by specialty, ACDU and Reserve:		
9420—Officer in charge, Naval Shore Act	0–0	3–0
9421—Commanding officer, shore activity	22–9	11–0
9436—Executive officer, shore activity	0–1	0–0
0002—Staff medical officer	29–2	33–21
0004—Director of Clinical Medical Svcs	3–0	2–0
0008—Regional Hlth. care coord	1–0	0–0
0010—Chairman of dept, teaching hosp	0–0	10–0
0016—Chief of clinical services	25–7	7–0
0020—Chief of service	29–0	45–0
0030—Medical research officer	0–0	45–12
0045—Flight surgeon	240–129	64–36
0048—Head of medical department	5–3	11–1
0051—Emergency medical specialist	13–10	1–20
0070—Primary care medical officer	988–502	365–313
0090—Undersea medicine	45–25	31–9
0101—Internist	158–53	64–221
0105—Pediatrician	25–0	3–111
0108—Family practitioner	186–59	47–95
0111—Dermatologist	31–18	4–25
0115—Psychiatrist	76–31	48–55
0118—Anesthesiologist	239–89	18–106
0121—Neurologist	15–4	3–81
0125—Physical medicine	0–0	0–1
0131—Radiologist	77–34	17–67
0135—Radiologist (therapeutic)	0–0	0–13
0140—Nuclear medicine	0–0	0–6
0150—Pathologist (anatomical)	1–3	0–5
0154—Pathologist (anat. and clin.)	40–16	7–43
0158—Pathologist (clinical)	0–0	0–6
0160—Preventive medicine officer	5–0	13–5
0163—Preventive medicine (aerospace)	42–0	8–7
0166—Preventive medicine (occupational)	2–0	25–3
0169—Preventive medicine (Public Hlth.)	0–0	5–4
0214—General surgeon	340–116	42–128
0224—Neurosurgeon	46–25	3–21
0229—Obstetrician/gynecologist	45–16	9–117
0234—Ophthalmologist	38–21	4–53
0244—Orthopedic surgeon	183–80	17–77
0249—Otolaryngologist	48–20	4–50
0254—Plastic surgeon	2–2	2–12
0264—Thoracic and cardio surgeon	22–9	1–17
0269—Urologist	34–18	4–37
2XXX—Non-Corps specific billets	4–0	0–0
0610—Health care operations officer	12–0	0–0
9420—Officer in charge, Naval Shore Act	9–0	0–0
9421—Commanding officer, Shore Act	9–0	0–0
9436—Executive officer, Shore Act	9–0	0–0
2160—Designated project officer	0–0	1–0
Students	0–0	113–0
TPSD [1]	0–0	126–0
Replacement/other	0–0	235–814
Total	3091–1301	1451–2592
2. Nurse Corps requirements by specialty ACDU and Reserve: [2]		
2XXX—Non-Corps specific billets	17–0	
0905—Director of Nursing Service	26–9	24–0

NOBC	Deploy systems ACDU/RES	CONUS ACDU/ RES
0915—Nursing Service Administrator	25–20	4–21
0920—Patient care coordinator	200–49	14–37
0925—Clinical specialist	0–0	0–24
0932—Operating room nurse	457–168	49–222
0935—Outpatient care nurse	122–20	285–2
0940—Charge nurse	927–380	0–318
0944—Staff nurse	1800–1250	74–1033
0952—Anesthetist nurse	243–62	20–144
0963—Primary care nurse practitioner	40–28	3–46
0982—Nursing education coordinator	7–0	1–12
0986—Nursing instructor	2–0	45–19
0990—Advanced nursing education	0–0	12–4
0995—Research nurse	0–0	2–1
0000—Students	0–0	21–0
TPSD	0–0	83–0
Replacements/others	0–0	227–1201
Total	3866–1986	864–3084
3. Hospital corps requirements by specialty—ACDU and Reserve:		
8000—General service corpsman	10038–4652	3733–6002
8294—Inflight medical specialist	34–0	45–78
8402—Nuclear sub medicine technician	265–35	72–57
8404—Field medical service technician	4482–1602	72–184
8406—Aviation medicine technician	583–134	98–159
8407—Nuclear medicine technician	40–2	17–23
8408—Cardiopulmonary technician	81–40	19–112
8409—Aviation physiology technician	17–2	99–9
8416—Clinical nuclear medicine technician	6–0	16–67
8425—Advanced hospital corpsman	971–206	365–449
8432—Preventive medicine technician	469–115	185–398
8433—Transplantation technician	0–0	3–52
8444—Ocular technician	29–8	20–115
8445—Advanced Ocular technician	33–16	11–62
8446—Otolaryngology technician	78–20	4–120
8451—X-ray Technician basic	212–50	76–125
8452—X-ray Technician advanced	555–184	297–254
8454—EEG technician	16–10	3–29
8463—Optometry technician	56–17	61–131
8466—Physical therapy technician	262–172	129–63
8472—Medical photography technician	8–6	7–37
8477—Biomed equipment repair technician basic	89–32	0–89
8478—Biomed equipment repair technician advanced	289–84	35–189
8482—Pharmacy technician	603–269	306–380
8483—Operating room technician	1739–600	261–571
8485—Neuro-psychiatry technician	199–94	37–400
8486—Urology technician	40–18	6–69
8489—Cast room/orthopedic technician	206–78	25–108
8492—Special operations technician	96–35	44–22
8493—Medical deep sea diving technician	65–19	63–24
8495—Dermatology technician	55–20	57–2
8496—Embalming technician	16–0	0–9
8501—Laboratory technician	381–128	85–432
8503—Histology technician	3–0	1–37
8505—Cytology technician	5–0	54–34
8506—Laboratory technician advanced	1020–358	351–694
8541—Inhalation therapy technician	65–39	5–110
951X—	0–0	25–0
9515—EOPS specialist	1–0	0–0
9519—Alcohol treatment specialist	2–0	0–0
958X—	0–0	41–0
9580—Master chief petty officer of command	3–4	0–0
9588—Career information coordinator	8–0	0–0
TPSD [1]	0–0	1070–0

NOBC	Deploy systems ACDU/RES	CONUS ACDU/RES
Students	0-0	3072-0
Replacement/other	0-0	1562-7159
Total	23120-9049	12432-18855
4. Dental technician requirements by specialty-ACDU and Reserve:		
8700—General service dental technician	1051-344	1576-751
8703—Advanced dental technician	244-44	182-34
8705—Dental hygiene technician	0-0	2-17
8707—Field dental service technician	337-114	1-9
8714—Research dental technician	0-0	17-4
8732—Dental repair technician	43-9	59-29
8752—Prosthetic technician basic	145-31	90-160
8753—Prosthetic technician advanced	128-29	134-3
8765—Maxillofacial technician	5-0	7-0
958X—Master chief petty off. of command	0-0	4-2
990X—	0-0	16-0
TPSD [1]	0-0	127-0
Replacements/other	0-0	133-548
Total	1953-571	2348-1567

[1] Transient, patients, separations, and detainees.
[2] Includes rapidly deployable medical facilities (RDMF) numbers.

Senator GLENN. Also indicate your fiscal year 1986 projected supply, both active and reserve, for each specialty of medical personnel.

Admiral SEATON. The projected inventories of physicians and nurses are provided below with the following exceptions:

a. Reserve physicians, nurses, and enlisted personnel are not projected by specialty, only by composite numbers.

b. Active duty nurses are not projected by specialty, only by composite numbers.

Fiscal year 1986:	
Physicians (ACDU/res)	3961-1299
Nurse Corps (ACDU/res)	3251-1276
Enlisted (ACDU/res)	49094-3400

Physician specialty inventories based upon projected end strengths

NOBC and specialty: [1]	*1986*
0070—GMO	651
0045—Flight surgeon	267
0090—Undersea medicine	78
0214—General surgery	127
Pediatric surgery	2
Oncologic surgery	0
Colon-rectal surgery	1
Hand surgery	4
P/V surgery	6
Renal transplant	0
0229—OB/GYN	112
O/G Mat-fetal	6
O/G oncology	7
O/G perin phys	1
0244—Orthopedics	89
Pediatric ortho	3

[1] In specialty counts, certain categories have not been included: for example, executive medicine, graduate medical education, flight surgeon, and undersea medical students.

1. Fiscal year 1986 enlisted hospital corps inventory projections:

NEC:	*Inventory*
8000—General service corpsman	26,254
8402—Nuclear submarine medicine technician	385
8404—Field medical service technician	5901
8406—Aviation medicine technician	602
8407—Nuclear medicine technician	83

8408—Cardiopulmonary technician	119
8409—Aviation physiology technician	1,075
8416—Clinical nuclear medicine technician	113
8425—Advanced hospital corpsman	1,413
8432—Preventive medicine technician	656
8433—Transplantation technician	72
8444—Ocular technician	181
8445—Advanced ocular technician	70
8446—Otolaryngology technician	106
8451—X-ray technician basic	335
8452—X-ray technician advanced	624
8454—EEG technician	45
8463—Optometry technician	210
8466—Physical therapy technician	211
8472—Medical photography technician	48
8477—Biomedical equipment repair technician basic	179
8478—Biomedical equipment repair technician advanced	249
8482—Pharmacy technician	1,008
8483—Operating room technician	1,038
8485—Neuro-psychiatry technician	409
8486—Urology technician	81
8489—Cast room/orthopedic technician	92
8492—Special operations technician	239
8493—Medical deep sea diving technician	150
8495—Dermatology technician	55
8496—Embalming technician	20
8501—Laboratory technician	609
8503—Histology technician	41
8505—Cytology technician	38
8506—Laboratory technician advanced	1,127
8541—Inhalation therapy technician	99
Total	43,937

2. Fiscal year 1986 Enlisted Dental Technician Inventory Projections:

NEC:	*Inventory*
8700—General service dental technician	3,857
8703—Advanced dental technician	262
8705—Dental hygiene technician	7
8707—Field dental service technician	380
8714—Research dental technician	18
8732—Dental repair technician	100
8752—Prosthetic technician basic	349
8753—Prosthetic technician advanced	176
8765—Maxillofacial technician	8
Total	5,157

MANPOWER/AIR FORCE

Senator GLENN. Please provide your total fiscal year 1986 wartime requirement, both active and reserve, for medical personnel. Include the number of physicians by speciality, the number of nurses by specialty, and the number of enlisted medical personnel by specialty. Also indicate your fiscal year 1986 projected supply, both active and reserve, for each specialty of medical personnel.

General CHESNEY. Depicted below is our wartime manpower for fiscal year 1986 which is based upon the criteria set forth in the Defense Guidance for the fiscal year 1987-91 Air Force Program Objective Memorandum (POM). Manpower supply is based upon projected fiscal year 1986 authorizations.

	AFSC	Active req'd.	Active fiscal year 1986	ARF req'd.	ARF fiscal year 1986
Specialty service:					
Anesthesiology	9566	257	52	105	31
ENT	9446	62	53	10	12
General	9416	769	269	249	179

	AFSC	Active req'd.	Active fiscal year 1986	ARF req'd.	ARF fiscal year 1986
Neuro surgery	9416F	259	11	10	0
OB/GYN	9496	44	203	0	37
Ophthalmology	9436	88	52	33	25
Orthopedics	9486	569	147	112	91
Plastic	9416G	15	10	44	0
Thoracic	9416A	108	8	53	0
Vascular	9416E	38	7	10	0
Urology	9426	150	51	59	16
Total		2,359	863	693	391
MEDICINE					
General					
Family	9346	423	480	266	338
Aeromed	9356	751	564	354	605
Peds	9366	20	276	0	21
Emergency	9396	45	31	14	16
Internal	9386	200	422	191	69
Dermatology	9556	12	41	8	4
Neurology	9576	19	31	12	3
Psychiatry	9586	212	141	125	21
Physical	9376	0	3	0	0
Total		1,682	1,989	970	1,077
OTHER					
Pathology	9526	104	119	33	15
Radiology	9536	119	183	52	23
Total		223	302	85	38
SPECIAL					
Staff/other	9316	63	22	67	12
Med ed		200	850	87	0
Gen. officers		24	20	6	11
Total		4,551	4,046	1,908	1,529
NURSES					
Staff	9716	264	267	85	82
M.H.	9726	324	165	101	55
O.R.	9736	764	316	152	123
Anest	9746	721	282	136	123
Clinical	9756	4,354	3,566	1,748	1,094
Flight	9766	162	157	1922	1,469
Midwife	9776	44	52	3	2
E.H.	9786	36	54	16	0
General Officer	0002	1	1	0	1
Total		6,670	4,860	4,163	2,949
ENLISTED					
Medical technician	90XXX	17673	8764	9497	8073
Surgical technician	90XX2	1352	1156	1116	379
Superintendent technician	9XXXX	16732	12221	5409	706
Eqpt technician	918XX	992	556	330	174
Total		36,749	22,697	16,352	9,332

These figures are obtained from computer models that assign all surgical and related tasks to a surgical specialist. Past experience and current analytical studies confirm the fact that many "surgical tasks" can be accomplished by the substitution of a "non-surgeon". We place great potential value on the ability of surgical specialists to substitute for one another and on the broad capability of our medical officers including flight surgeons to assume some surgical roles. All Air Force physicians

are being trained to high levels of advanced trauma life support skills and military medicine knowledge. Air Force Medical Service leaders exercise professional judgment in substitution among members of the Medical Corps. Current studies of the specific required skills are expected to more precisely define our capabilities in this area. We remain optimistic regarding the capability of our people to react in times of medical crisis. We are convinced that the total physician complement will be effectively utilized in time of conflict. Although the optimum specialty mix is important, we place great emphasis on the total number of providers available and the potential to substitute certain providers in areas of skill shortages.

DEPLOYABLE MEDICAL HOSPITALS/OJCS

Senator GLENN. General Toner (and each Surgeon General), what is our current requirement for deployable medical hospitals in Europe? How many do we currently have in each service, and how many are programmed to be bought in the current Five Year Defense Program?

General TONER. Sir, our current requirement is for [deleted] hospitals for the European Command. Our present figures show that Army has [deleted], Navy has [deleted] and Air Force has [deleted] now and will have [deleted] by the end of the calendar year. The services programs indicate that a total of [deleted] hospitals are identified to be procured over fiscal year 1987-1991. Included in the Five-Year Defense Plan are modernization hospitals Army is procuring as replacements for some existing units.

DEPLOYABLE MEDICAL SYSTEMS EUROPE/ARMY

Senator GLENN. What is our current requirement for deplcyable medical hospitals in Europe? How many do we currently have in each service, and how many are programmed to be bought in the current Five Year Defense Program?

General BECKER. The total Army requirement for deployable medical hospitals to support Europe is 118 combat hospital units. This total hospital requirement is based on an approved requirement for hospital beds to support Europe, [deleted]. To meet this total requirement there are 20 Active Component combat hospitals forward deployed in Europe. [Deleted]. The remaining requirement [deleted] must be provided by the deployment of CONUS based Reserve Component hospitals to Europe. [Deleted] of the required 118 hospitals are equipped. Acquisition of the remaining requirements began with the fiscal year 1984 budget and continues through the fiscal year 1987-91 Five Year Defense Plan (FYDP). Funding for all remaining requirements is included in the fiscal year 1987-91 FYDP.

DEPLOYABLE MEDICAL HOSPITALS/NAVY

Senator GLENN. What is our current requirement for deployable medical hospitals in Europe?

Admiral SEATON. The current requirement for Navy deployable medical hospitals (Fleet Hospitals) in Europe comprises [deleted] beds. Initial Operating Capability (IOC) of the first Fleet Hospital for pre-positioning in Europe is [deleted].

Senator GLENN. How many do we currently have in Navy, and how many are programmed to be bought in the current Five Year Defense Program.

Admiral SEATON. Please see below.

NAVY ACQUISITION PLAN

[Deleted.]

DEPLOYABLE MEDICAL HOSPITALS/AIR FORCE

Senator GLENN. What is our current requirement for deployable medical hospitals in Europe? How many do we currently have in each service, and how many are programmed to be bought in the current five year Defense Program?

General CHESNEY. The Air Force's current requirement for deployable medical hospitals in Europe is twenty-nine; we currently have [deleted] 500 bed hospitals prepositioned in Europe with [deleted] more scheduled for delivery by the end of calendar year 1985. Eighteen are programmed for procurement in the Five Year Defense Program.

DEPLOYABLE MEDICAL HOSPITALS/OJCS

Senator GLENN. General Toner, what is the total cost of the type of 250-bed or 500-bed deployable hospitals currently being purchased by the services?

Are the services all buying similar deployable hospitals, or do these hospitals differ by service?

General TONER: Sir, the cost of 500-bed deployable hospitals ranges from $11 million for the Army to $27 million for the Navy. Differences in cost are attributed to the missions given these facilities by the services. Army communication zone hospitals are not surgically intensive, have limited intensive care units and are dependent on other Army organizations for mobility and logistic support. By contrast, similar Navy hospitals have more operating rooms and differ significantly in the amount of self-sufficiency given to the hospital, sophistication and number of shelters, and quantities of organic vehicles and equipment.

To answer the second part of your question sir, the services are procuring deployable hospitals that differ in size, composition of materiel and associated support equipment based on service functional and organizational requirements. Within the hospital shell, the services have standardized medical equipment, deployable medical systems (DEPMEDS). Prior to 1984, the services were buying separate units, not fully standardized by the Defense Medical Standardization Board (DMSB). However, beginning in fiscal year 1984, a quad-service agreement was reached regarding the use of standard equipment in DEPMEDS. Army's DEPMEDS cost for a 500-bed communications zone hospital is $8.6 million compared to Navy's $10.8 million for a similar facility, the cost differential is based on differing capabilities I outlined earlier.

Senator GLENN. General Toner, how many of the deployable hospitals in Europe today are actually pre-positioned at or near sites where they would be used?

General TONER. The services have [deleted] deployable hospitals in Europe today. Additionally, there are [delete] hospitals stored in CONUS that will deploy to the European theater. The majority of the units stored in Europe are located at or near their intended sites. In those few cases where this is not true, storage facilities and/or limitations of storage facilities prevents the services from locating the deployable hospital in the most advantageous position.

DEPLOYABLE MEDICAL HOSPITALS/SECRETARY OF DEFENSE

Senator GLENN. Dr. Mayer, one of the Department's recently announced initiatives to improve medical readiness in Europe was "to eliminate potentials for duplication of sites for hospital and evacuation units among services and thus facilitate joint utilization."

The final report on this effort was due by August 1, 1985. Has it in fact been completed?

Dr. MAYER. No, it has not been completed. This was one of six initiatives on the part of the EUCOM Surgeon's Office who also established the date of 1 August as a goal for completion of this initiative. I understand they are making progress on this initiative and after appropriate review by the CINC and the OJCS we expect to be informed of their results.

Senator GLENN. Dr. Mayer, if there is little joint planning for cross-service use of wartime medical facilities as the Zimble Report and your statement suggest, then how can we be sure that the $500 million for 29 additional hospitals in the FY1986 Budget, much less the billions programmed over the next five years, are actually needed and will be deployed in a coordinated manner that makes the most sense from a joint service point of view?

Dr. MAYER. The $500 million in the fiscal year 1986 Budget and the money programmed over the next five years provides a very minimal structure with no fat. It will be five years before we achieve the requirement of providing this minimally adequate care on the battlefield.

I must also point out that the program we have established will meet a 15-day evacuation policy. That is, we are only buying that amount of deployable medical support to enable the services to return to duty those that can be treated within the 15-day period; otherwise, they would evacuate the patients back to CONUS.

I might add, some of our efforts in improving our wartime capabilities are not being supported by the Congress. Our project to construct an essential hospital facility in Korea, for example, Kimhae, has been eliminated from the MILCON budget. These actions make our enhancements difficult. We have made progress in the methodology whereby the services calculate their requirements. Each service is now using the Joint Operations Planning System Medical Planning Module, and my staff is monitoring this programming process.

We are not at the point yet where I would like us to be, but we are making progress. Joint planning and coordination will continue to be one of my top priorities.

READINESS OF MILITARY MEDICAL UNITS/OJCS

Senator GLENN. Can you give us a brief summary of the readiness ratings, or C-ratings, of the medical units in each service? What percentage of medical units in each service are rated C-1 and C-2 (fully or substantially ready)? what percentage are rated C-3 (marginally ready) and what percentage are rated C-4 (not ready)?

General TONER. Sir, the overall medical readiness rating is at [deleted].

General TONER. Individual service ratings are:

	C-1/C-2	C-3	C-4
Army			
Navy	[Deleted]		
Air Force			
Marine Corps			

[Deleted].

Senator GLENN. What is the main constraint on medical unit readiness? Is it lack of personnel, equipment, or training?

General TONER. The main constraint on medical readiness is [deleted].

HOST NATION SUPPORT/OJCS

Senator GLENN. General Toner, what progress are we making in negotiating Host Nation Support agreements with our NATO allies that will reduce our wartime requirement for deployable medical facilities and for medical personnel?

General TONER. Host Nation Support is being worked very aggressively. Our brief outline provided earlier indicates that USEUCOM is hard at work at negotiating support. However, due to the current shortages that exist in our medical capability, Host Nation Support will not, nor should it, reduce our medical support requirements. It simply augments our capability for as long as the host nation does not degrade its capability to care for their own casualties.

Senator GLENN. Are there any NATO countries, for example, that have said they would make use of a certain number of fully staffed hospital beds for U.S. military use in wartime?

General TONER. Yes sir, USEUCOM has negotiated with the [deleted].

Senator GLENN. General Toner, have any of the military services lowered their requirements for deployable hospitals as a result of Host Nation Support agreements or commitments by our NATO allies?

General TONER. The services have not lowered their requirements.

Senator WILSON. The hearing is adjourned.

[Whereupon, at 12:45 p.m., the subcommittee adjourned, subject to the call of the Chair.]

MILITARY MEDICAL CARE SYSTEM

TUESDAY, SEPTEMBER 24, 1985

U.S. SENATE,
SUBCOMMITTEE ON MANPOWER AND PERSONNEL,
COMMITTEE ON ARMED SERVICES,
Washington, DC.

The subcommittee met in open session pursuant to notice, at 9:44 a.m., in room SR-232A, Russell Senate Office Building, Senator Pete Wilson (chairman) presiding.

Present: Senators Wilson, Goldwater, Thurmond, Denton, Kennedy, Bingaman, and Glenn.

Staff present: Alan L. Chvotkin, counsel; Patrick A. Tucker, counsel; Arnold L. Punaro, staff director for the minority; David L. Lyles, professional staff member; Patricia L. Watson, research assistant; and Mary J. Kampo, staff assistant.

Also present: Gerald J. Smith, assistant to Senator Goldwater; Mark J. Albrecht, assistant to Senator Wilson; Allan W. Cameron, assistant to Senator Denton; Jeffrey B. Subko, assistant to Senator Exon; Gregory B. Craig, assistant to Senator Kennedy; Edward McGaffigan, Jr., assistant to Senator Bingaman; and Phillip P. Upschulte, assistant to Senator Glenn.

OPENING STATEMENT BY SENATOR PETE WILSON, CHAIRMAN

Senator WILSON. Good morning, ladies and gentlemen.

This is the second in a series of Manpower and Personnel Subcommittee oversight hearings on the military medical care system.

Last Thursday, in our first hearing, we focused on the primary purpose of that system, providing medical care to the members of our Armed Forces in the event of armed conflict, and we found that we are not capable of providing the care that we think we would need in that situation. Even though we are making some progress to be ready in the event of a war, it will be several years, under even the most optimistic forecasts, before our military medical system will be fully capable of meeting the needs of our forces in wartime.

Unfortunately, very little attention has been paid to this problem by the press or by the public.

I hope that in the coming months we can direct attention to this most important problem in the military medical system.

Today, however, we are shifting our focus to the ancillary, but extremely important, mission of providing medical care during peacetime.

Presently, there are more than 10 million people entitled to receive medical care from the military medical system. This includes

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the 2.2 million people on active duty and 1.5 million retirees. The remainder of that 10 million people, amounting to almost 7 million, who are entitled to military medical care are the families of active duty personnel and of our retirees.

But, just because the system is large does not mean that we can, or that we will, settle for anything less than the very best medical care for each and every person who is entitled to receive that care.

For the past couple of years, there have been countless reports of cases in which people did not receive that high quality care. Most recently, we have the case of the recruiting and credentialing of Dr. Billig at Bethesda Naval Hospital.

In February 1985, we had the case of an Air Force pathologist at Keesler Air Force Base, in which a substantial number of totally inappropriate diagnoses covering a number of years was revealed. Twice in the last 3 years, we have found that retiring Surgeons General failed to take appropriate management actions when presented with allegations involving patient care by senior physicians under their command.

Incidents such as these should never have occurred, and they cannot be allowed to recur.

Every medical care system, even those much smaller than the military system, will experience cases of individual malpractice, of poor judgment, and of error.

However, we must insure that our military system has procedures and safeguards established and, when in force, procedures which will minimize, if not eradicate, these cases.

A June 1985 Department of Defense audit of medical quality assurance raises substantial questions about the system's ability to enforce those safeguards and procedures.

The report found, and I quote from it:

> That facilities were not fully complying with the Joint Commission on Accreditation of Hospitals guidance regarding verification of applicant data prior to granting privileges, completeness of medical records, emergency room staffing, performance of patient care assessment reviews, and performance of utilization reviews.

A January 1985, Department of the Air Force audit was even more critical.

The overall evaluation of the program was that:

> The Air Force Medical Service Quality Assurance Program was not effective because hospital commanders had not established adequate internal controls to insure potential quality of patient care problems were identified and reviewed.

Today we will hear from the Assistant Secretary of Defense for Health Affairs and from the three Surgeons General, who were our panelists at last week's presentation on wartime care.

I intend to ask each of them how these conditions that we have recited have been permitted to occur because these are the very people charged with the duty of seeing that they do not occur.

Before hearing from our witnesses, I would like to announce that the subcommittee will hold its next hearing in this series of hearings on military medical care on October 8, beginning at 10:30 a.m. At that hearing, our witnesses will be some of the beneficiaries of the peacetime military medical system and some experts from outside the administration whose perspectives may differ from those of our witnesses this morning.

Before proceeding to hear from our panelists, I would like to invite the distinguished ranking member of the subcommittee, Senator Glenn, to make whatever opening statement he may wish to make at this time.

Senator GLENN. Thank you very much.

We are meeting all the time. We are going to have to stop meeting like this gentlemen. [General laughter.]

I know you would welcome that, probably.

But we are into some very important and interesting things here.

I want to join in welcoming Dr. Mayer and all the Surgeons General back to the subcommittee this morning.

This morning's hearing on peacetime medical care delivery in the Department of Defense is of great personal interest to me. Our troops, of course, and very rightly, expect quality medical care.

The Congress and the Defense Department have an obligation to let them know that we can provide medical care for them and their families in peacetime as well as in wartime.

Last week, the subcommitttee heard testimony about some very serious shortcomings in our wartime medical readiness posture. In preparing for today's hearing on peacetime health care delivery in DOD, I learned that in a recent survey active duty beneficiaries of the military health care system perceived civilian care to be better than military care.

Mr. Chairman, we are spending $10 billion on a military health care system in the Department of Defense. From the testimony last week, we didn't feel it was fully ready for war. It is also perceived by its primary beneficiaries as inferior to civilian health care in peacetime. So, we can sure make improvements on that. Something is wrong.

In my opinion, we need to closely examine the priorities of the entire military health care delivery system to see if the deficiencies can be corrected within that system or whether more fundamental changes, organizational changes, differences of direction need to be considered or will be necessary.

I look forward to hearing the testimony this morning and we will have questions after that.

Thank you very much.

Senator WILSON. Thank you, Senator Glenn.

Senator Goldwater, do you have an opening statement?

Senator GOLDWATER. I did not intend to make one. I am just glad to be here.

I imagine that I have spent more time in military hospitals than anybody around here. I have found some problems that are common with all hospitals.

I think the biggest problem with the military medical service is the fact that we don't pay enough for our people. A young graduate of medical school going on duty as a doctor in any military hospital will find within 4 years his classmate is making a lot more money than he is, and then he is tempted to get out; and a lot of them do. I have nothing but admiration for the man who makes a military career out of medicine. He is giving up a lot when he does that.

I would like to see us do something to encourage highly competent men and women to remain in the military medical service. I

think then that all the problems we are talking about would be answered.

We have a service called CHAMPUS that costs us a lot of money every year. There are over 100,000 people who live right around my hometown, and we have two little military hospitals trying to take care of 100,000 people. When you talk about costs, I don't know how we do it for $10 billion, but we try.

I just want to hear what is going on, so I will keep quiet.

Senator WILSON. Thank you, Senator Goldwater.

Senator Kennedy, do you have an opening statement?

Senator KENNEDY. Thank you, Mr. Chairman. I have just a brief comment.

We are here this morning to examine the military's peacetime medical care system, and in the past couple of years there have been a number of scandalous revelations about quality of care available in the military health services. It is in part because of these revelations that we are taking a closer look today.

Medical audits have turned up alarming deficiencies in the systems that should be in place to assure and assess quality of care. The absence of a more convincing plan for assuring quality and with the firm belief that military personnel and their families deserve the same high quality care as everyone else, I have been supportive of repealing the *Feres* doctrine. I think there is one standard, obviously, in wartime or in strictly military functions. But I do think that we ought to be sensitive to the problems of malpractice and negligence in peacetime.

The quality of care in military health facilities must be exemplary; our armed services personnel deserve no less and will not accept any less from our Department of Defense.

This is a time of great ferment in the health care sector at large, of far reaching experimentation, with new forms of organization and financing and the breaking of new ground in health care delivery. There is no reason that military personnel should not also reap the benefits.

We would like to speed that process along. The list of potential innovations is long: the use of HMO's, PPO's, the preferred provider organizations, the independent practice associations, the diagnostic related groups, ambulatory surgery, preventive care, case management. There has apparently been small degree of exploration of few of these approaches in the Defense Department. We will get back to those later on during the questioning period.

There must be more serious analysis.

We will also examine the interplay between the peacetime medical system and military readiness this morning. This is a very important topic that merits careful and methodical examination.

It is commonsense that the wartime medical personnel must stay in active practice during peacetime to keep their skills sharpened, and this caveat makes it more difficult to consider targeting the military medical system at wartime readiness only.

There is also considerable graduate medical education supported by the armed services. There is a reduction in the civilian area, so it creates new opportunities in terms of the military, greater flexibility. And the changes in the peacetime system have implications for graduate medical education which I believe must be explored.

I am pleased that we are having these hearings, Mr. Chairman, and I welcome the opportunity to participate.

Senator WILSON. Thank you, Senator Kennedy.

Senator Denton?

Senator DENTON. Mr. Chairman, I think you have probably gone into this current situation in military health care to a greater degree than I. Having been a beneficiary of that care for 34 years active duty, and still having myself and my family taken care of by it, I will make only some brief comments.

I would imagine that one of the problems we are going to find any time we look into the military health care question is going to result from our propensity to do such things as back off from our commitments for defense spending. We agreed to authorizations for a defense buildup, then reduced that to an agreement between the House and Senate to go up only with inflation, and then we have seen the House try to renig on that. When we do that, the service chiefs are constrained severely by their consciences respecting the differences in hardware and numbers of personnel in various categories, giving first priority to the hardware. Not only does the medical end suffer from the military necessity to salute and march off and say, "Yes, we can do it," even after Congress backs off from its agreements, but so do many other segments of service life.

We end up with the service chiefs having said as they come aboard—and I have seen this for 34 years:

> We will not hurt our people. We are going to at least give enough recognition to the needs of our people in terms of being with their families, in terms of health care, in terms of family separation, that sort of thing, so they can live like normal human beings.

And then they all break those promises because they find themselves being squeezed a lot by the budget.

Now, I am not saying that there aren't going to be some problems that we can uncover here and fix, because I don't know what we can uncover.

We have maintained that we have spent $10 billion on medical care, health care, in the services. We could point to the fact that the active duty personnel must have quality care. We have a volunteer force. But the retired personnel complain to our Senate offices that they don't have convenient and adequate medical care, and we can present these witnesses sitting before us with those facts.

I just hope that sometime during their testimony we are attentive to what they say about the exigencies which exist only in the services respecting medical care. For example, my prepared opening statement deals with the fact that no matter where you have service personnel, they expect, if they are men, that their families are going to be taken care of, and the women expect OBGYN services people, and the men expect orthopedic surgeons there.

Well, when you splinter it up into as many little bases as we have around the world, it gets to be a pretty tough problem.

You get into things like helicopter evacuation of patients who are family members sometimes, and those expenses have something to do with the $10 billion.

I will not be able to stay here this morning. I have four hearings scheduled at one time. But I shall read the testimony with great care, and I would ask in advance if the witnesses would try to ad-

dress whether or not in these days there is more or less care available to retired personnel than there was, say, 10, 20, or 30 years ago.

I would ask that you address that question.

[The prepared statement of Senator Denton follows:]

PREPARED STATEMENT OF SENATOR JEREMIAH DENTON

Thank you, Mr. Chairman. I am pleased that the Subcommittee is holding this series of hearings on military health care, and I am particularly pleased that we are having today's hearing on the peacetime military health care system.

As a career military officer, like our distinguished Ranking Minority Member (Senator Glenn), I well understand the importance of our military health care system to our service personnel and their families. Indeed, with the possible exception of pay, there is probably no issue that is more important for the morale of the troops.

Whenever I have visited military installations and talked with officers and men, I have found that concerns and complaints about health care are at the top of the list of things that they want to discuss with me. Those concerns do not center on the quality of care, which generally is thought to be pretty good, but upon its availability.

The availability issue has two parts. First, there is concern about the access of dependents to care. A service member can take a lot himself, but if it is a question of medical attention for his family, his tolerance level is much lower. Even if the care if available, there is great concern if there is a long wait, or if there is no consistency in what individual doctor is seen to treat ongoing problems.

Second there is a concern about the availability of the right kind of care. The service personnel want to have the right kinds of doctors at the installation's military hospital. If the service member or a dependent has an orthopedic problem, he wants an orthopedic surgeon at the hospital and does not want to have to go out through CHAMPUS to get that kind of care. A woman in the service is concerned about qualified OBGYN doctors, and wives and husbands both look for the availability of qualified obstetric and pediatric health care personnel.

I recognize, of course, that it is a difficult task to have military hospitals respond to all those civilian needs and still be able to handle effectively the wartime missions that the Subcommittee considered last week. In fact, it may be impossible for us to do it. I have no easy answer to the dilemma that is poised, but I will look forward to whatever comments our witnesses may wish to make about it.

I do want to stress, however, that the men and women who staff and operate the military health care system are overwhelmingly well-qualified, devoted, concerned, and effective. They take care of me and my family, and they have for years, so I know. It may be that their task is impossible, but any major failures or deficiencies of the system are not the fault of the men and women who staff it.

I hope that we will avoid the trap of accusing the system as a whole because of the mistakes or failures of a few individuals. Obviously we want to prevent the mistakes, but we need to remember that the system as a whole is typified by good care.

I should also add that I frequently hear complaints from military retirees who believe that they do not have the kind of access to care that they were promised. We understand the priorities, of course, but it is frequently difficult to sell those priorities to an individual who believes that he is entitled in his retirement to care that is both available and convenient. That is an aspect of the problem that we cannot ignore in Congress, an aspect upon which we need your input.

Mr. Chairman, I look forward to hearing our witnesses today. The problem is an important and difficult one, but it is one that is inevitable if we are to have an all-volunteer armed force. Perhaps this is a consequence of the all-volunteer force that we did not fully consider at the time.

Thank you, Mr. Chairman.

Senator WILSON. Thank you, Senator Denton.

Also, for the record, Senator Thurmond, who was here, has asked that his statement be placed in the record.

That will be done, without objection.

[The prepared statement of Senator Strom Thurmond follows:]

PREPARED STATEMENT BY SENATOR STROM THURMOND

Mr. Chairman, it is a pleasure to join you for the second of this series of hearings on military health care. Last week's hearing on wartime medical readiness brought out some rather disturbing points about our capability to care for our troops in time of war.

Mr. Chairman, I would like to add my welcome to our witnesses for today's hearing. It is a pleasure to have you gentlemen here to present testimony.

Mr. Chairman, as you point out in your statement, the military provides health care to about 10 million people in peacetime. This is a tremendous task by any standard of measurement. Despite the difficulty of the job, we cannot accept any less than the best care for our military personnel and their families.

The reports that have been furnished by to the Committee indicate procedures to ensure professional competence are not strictly followed by the services. Rules and regulations are only effective if they are enforced.

I find it disturbing that the Department of Defense audit found repeated incidents where emergency room personnel did not meet minimum service requirements for assignment to emergency room duty.

The chain of command should and must be held accountable for its actions and inactions because it is their duty to ensure the well being of our military personnel and their familes. Thank you, Mr. Chairman.

Senator WILSON. Dr. Mayer, General Becker, Admiral Seaton, General Chesney, and Mr. Gilliat, I welcome you here this morning.

Each of your prepared statements will be inserted in the record in its entirety. I would therefore ask that you summarize your statements and your oral presentations and that you limit those to 5 to 10 minutes so that we will have adequate time for questioning.

Dr. Mayer, we are pleased to welcome you back.

I should say in fairness, having said that we have invited these people here because they are the ones responsible for health care, that they are also, in the case of Dr. Mayer, responsible for requesting the DOD audit, and I believe in the case of General Chesney, responsible for requesting the Department of the Air Force audit, which have brought to light some of these deficiencies.

Gentlemen, we are eager to hear from you.

Dr. Mayer, you may proceed.

STATEMENT OF DR. WILLIAM MAYER, ASSISTANT SECRETARY OF DEFENSE, HEALTH AFFAIRS, ACCOMPANIED BY ROBERT L. GILLIAT, ASSISTANT GENERAL COUNSEL, MANPOWER AND HEALTH AFFAIRS, DEPARTMENT OF DEFENSE

Dr. MAYER. Thank you, Mr. Chairman, Senator Goldwater, gentlemen.

Once again I want to repeat our gratitude, Senator Wilson, for conducting these hearings and giving us an opportunity to share with you the thoughts we have about the system and about the best ways to achieve the improvement that is clearly necessary in it.

There has been reference twice already this morning to the $10 billion that we are spending on military health care. That is a very substantial amount of money. But just to give some perspective on what we are doing, and Senator Denton did allude to this, we are presently operating 168 hospitals worldwide, some of them only a few beds in size in very remote locations, and some of them very large and beautiful.

We are staffing these facilities with about 170,000 persons—13,000 physicians—and nurses and corpsmen and all the other

medical people that we have come to rely on so heavily to deliver modern health care.

Senator DENTON. Mr. Chairman, did the gentleman say 170,000 or 13,000 physicians. I could not quite hear him.

Dr. MAYER. We have 170,000 total medical personnel, of whom 13,000 are physicians, Senator.

On any given day, there are 23,500 of our beneficiaries in a hospital, mostly in the military treatment system, some of them in CHAMPUS-supported hospitals.

We are admitting 1 million patients a year to our military hospitals alone, and in our military facilities, which were designed mainly as hospitals, we are seeing 56 million outpatients a year.

So this is a truly vast system. And, as you all recognize, it is operated in a tremendous variety of settings and sometimes against great odds.

In managing this enormous system, an area of greatest concern, not only to the Department and this subcommittee but to every one of our 10 million beneficiaries, is our all-consuming effort to provide high quality health care in our military facilities.

Unfortunately, recent media coverage of a number of incidents in which medical treatment problems have occurred—as they do in the finest hospitals all over this country, all over the world—in focusing on that, the suggestion is that our enterprise is somehow substandard or less than adequate.

I deplore that kind of interpretation because the overall standard of care in the military facilities—and I remain convinced of this, after nearly 30 years on active duty and another 10 years in the civilian health care system—I am convinced that the overall quality of care in military medicine is at least equal to if not better than care overall in the civilian sector.

It is a matter of great pride and honor to me that I have the opportunity to appear today with General Becker and General Chesney, also Admiral Seaton, the leaders of military medicine. They represent, really, the finest system that so far any armed force has been able to mount. They are well aware, as I am, of the problems we still face. They sometimes disagree with me or amongst themselves as to the best way to solve those problems. But you can be absolutely convinced that our principal concern is with the quality of the care we deliver, the adequacy of the care, and the access of our patients to that care.

Since coming to the Department about 2 years ago, I have forcefully carried out the strong commitment to quality that Secretary Weinberger enunciated very early on during this administration. Some of our more recent directives which we have issued to try to assure quality of care have dealt with problems of licensing of military health care personnel, which is going to be a difficult problem in some respects for technical reasons, the management of our clinical investigation funds and restrictions on off-duty employment of military physicians.

Our licensure directive, which was signed on July 18, requires that all military physicians, nurses, dentists, and clinical psychologists—and that list will be expanded—have exactly the same licenses as are demanded of their civilian colleagues.

These recent initiatives complement several earlier actions which put into place very exact standards and procedures for the credentialing of health care providers and for dealing with allegations of improper conduct or substandard patient care.

Some of these were in place quite a while ago, but most of them have been formalized and completely disseminated and executed through the publication of individual service regulations implementing them just in the last 2 years.

I am very much aware that just making plans and issuing directives does not guarantee quality of care. I want to emphasize to you that these standards and procedures that we have published are implemented fully now, and that the procedures are working.

We are also looking to new and innovative techniques to directly impact upon the military medical system. A recent example is our decision to adopt a program of external civilian peer review to supplement the quality assurance programs within our hospitals. This won't replace it. It won't even be able to duplicate the extent of quality of the programs that we are running. But it will, in a sense, monitor the programs that we are running to assure quality of care, and will support and strongly supplement those efforts.

As you know, we had a recent blue ribbon panel of outside civilian experts convened at the direction of this committee to examine the methods by which we determine the size of our medical facilities.

Their recently completed report recognized the overriding importance of medical readiness in determining both the size and the composition of our peacetime active duty medical force, as well as all of the facilities and workload in our direct care system.

The panel also advocated the establishment of firm guidelines to insure that future facilities' planning efforts be consistent with our readiness mission, and listed several initiatives for improving the management of the system in peacetime.

Those included such things as the following:

The completion and implementation without delay of a vast management information system which is currently under development, including an analytical force sizing methodology.

A survey of all DOD medical treatment facilities in order to best determine our systemwide requirements for replacement or modernization, instead of doing it individually service by service, but systemwide, and to prioritize those requirements on a truly triservice basis.

Shortening the amount of time it takes a medical construction project, which can be as long as 8 years from the time we originally conceive it and begin the planning, until the time the doors are open.

And, finally, adopting workload measurements and other resource allocation mechanisms that reward the cost-effective provision of quality care and eliminate the existing incentives for overutilization, particularly of inpatient services.

Secretary Weinberger fully endorsed the panel's findings, and we in Health Affairs are moving ahead smartly to implement each of its recommendations without any delay.

With respect to cost containment, which has been another major preoccupation, and while $10 billion is a lot of money, it is not an

openended amount of money, and it is an enormously expensive enterprise.

A major component of this strategy involves the demonstration authority provided by Congress which permits the Department to develop and implement projects which will help identify innovative methods of containing costs.

Already we have taken advantage of this new authority. We have tried three different HMO contracts in three different cities, and we have in place or well along in development a project at Fort Ord, CA, where we are using an Army facility to test the idea of giving the hospital commander complete responsibility for deciding on the most cost-effective method of providing medical care to all beneficiaries in this area, not just those that show up at this hospital, and giving him, in a sense, control over the delivery of care which, in the past, under CHAMPUS was not under his direct supervision.

The same concept is being considered for testing at an Air Force facility as well. A third demonstration project, also involving the Air Force, is designed to test the possibility of consolidating all three services, bone marrow transplant responsibility, which is emerging as a major and very costly technology by conducting the majority of these procedures at the Wilford Hall Medical Center in San Antonio.

In the Tidewater area of Virginia, we will be testing the feasibility of a fixed price contract to provide or arrange for all mental health care received by our beneficiaries in the civilian community.

That mental health care constitutes close to 18 percent of our CHAMPUS bill, and most mental health care is received outside the military facilities.

By testing these innovative methods of providing health care on a small scale, we will learn what methods have the most merit and potential for cost savings while preserving quality, which we may then be able to adopt for expansion throughout the whole system. Mr. Chairman, since coming to the Department some 2 years ago, I have devoted my energies primarily to three things: Improving the readiness of our medical system; second, the quality of care it provides in wartime and peacetime; and third, the cost effectiveness of the entire system.

We have made substantial progress in all three areas, though much more remains to be accomplished.

One thing that has become clear to me is that our reliance on our direct care system to accomplish in toto both our wartime readiness and peacetime benefit mission has placed significant strains on a system that was not basically designed to do that, and it placed strains on our ability to accomplish either one of those missions really effectively.

Pressed by the demand to provide comprehensive health care to some 10 million people, we have not been able to assure top priority to wartime readiness, as you pointed out in your opening statement. Thus our force structure does not meet our wartime requirements either in number or in mix.

Our training programs fail to adequately address these manpower priorities. Our peacetime benefit mission presents a workload that is not always relevant to developing and maintaining specialty

skills that are necessary for wartime. And, finally, civilian care services purchased under the CHAMPUS system, as presently constituted, are too costly, both to the Government and to the beneficary who has to pay 20 or 25 percent, and they do not take sufficient advantage of the competition that has now come to exist in the civilian health care marketplace.

I believe that the greatest challenges in the coming years are: First, to sort out our wartime readiness mission and our peacetime benefits mission; second, to improve substantially our ability to cost effectively utilize civilian health care resources to meet, perhaps, a larger portion of that part of the peacetime benefit demand which is not relevant to our readiness mission; and, third, to accelerate the redirection of our military direct care system to effectuate our top-priority commitment to medical readiness.

Meeting these challenges would likely require some departures from traditional methods of operation.

This will undoubtedly arouse a certain amount of resistance and a great deal of argument as to the best way to go.

But, if so, we still have to be ready to make such departures.

I want to make it very clear that we will not make any departure from our firm and total commitment to provide quality health care to dependents of our active duty forces and to retired members and to their dependents. Recent press stories that this may be among our plans are absolutely wrong.

Quite to the contrary, one of our principal objectives as we review the state of military health care is to improve the health care benefit for our dependents and retiree families. In many areas, our present system is plagued by long delays in obtaining appointments due to inadequate staff or space in order to accommodate the demand.

In addition, our beneficiaries who receive care from civilian providers often complain of the costs and administrative complexity of the CHAMPUS Program and sometimes the delays in reimbursement which the person himself may have to seek.

Under this program, we are providing 25 percent of all of our beneficiary care.

We believe the establishment of an effective military-civilian partnership in health can reduce costs and administrative burdens and increase satisfaction both for our beneficiaries and our professional staff alike, as well as allow us to better achieve our readiness mission.

We do not foresee a significant change in that 25 percent civilian delivered versus 75 percent military delivered workload split.

We may see a change in the type of work done in-house so that it best serves and is most relevant to the specialties and work force needed to meet our readiness requirements.

We also hope to change the way we pay for the 25 percent performed in civilian facilities in order to take full advantage of the expertise and competition which now exists in the civilian community and to provide better access and better continuity of care at potential savings to both the taxpayer and our beneficiaries.

That completes a summary of my statement, Mr. Chairman.

I would be very happy to answer your questions.

[The prepared statement of Dr. Mayer follows:]

Prepared Statement of William Mayer, M.D., Assistant Secretary of Defense for Health Affairs

Mr. Chairman, members of the subcommittee: I am pleased to have this opportunity to be back with you today to discuss the Department of Defense's efforts in managing our peacetime health benefit mission. With me today are the three Surgeons General: Lt. General Quinn Becker from the Army: Vice Admiral Lewis Seaton from the Navy; and, from the Air Force, Lt. General Murphy Chesney. Also in attendance is Mr. Robert L. Gilliat, Assistant General Counsel for Manpower and Health Affairs, who will be addressing any questions the Subcommittee may have regarding the Feres Doctrine and related issues. The focus of my remarks today will be in the areas of quality assurance and managing the system in a cost effective way. I would like to begin with a brief overview of the size and scope of the Department's medical activities in order to provide a framework within which to examine our efforts.

OVERVIEW

The fiscal year 1986 budget request for military medical operations is over $9.6 billion. This includes approximately $3.4 billion for the Army, $2.1 billion for the Navy, and $2.5 billion for the Air Force. Also included is nearly $1.5 billion for CHAMPUS, and $97 million for Medical Information Systems.

Nine point six billion dollars is an impressive sum of money, and the medical system which these dollars support is equally impressive. We operate over 500 facilities, worldwide, including 168 hospitals. These are staffed by over 170,000 physicians, nurses, administrators, medical corpsmen and other support personnel. On any given day, some 23,500 beneficiaries will be inpatients in these hospitals or under CHAMPUS and during the course of the year we will provide over 56 million outpatient treatments, and process more than 5 million claims from civilian providers.

QUALITY OF CARE

In managing this enormous system, an area of great concern not only to the Department and this Subcommittee, but to every one of our 10 million beneficiaries, is our all-consuming effort to provide high quality health care in our military medical treatment facilities. Unfortunately, recent media coverage of military medicine has focused on several incidents in which medical treatment problems have occurred—as they do in every medical enteprise, no matter how excellent. These selected incidents have been used to imply that most military medical care is not quality care.

I remain convinced that overall quality of care in military medicine is equal to, if not better than, care overall in the civilian sector, despite the relatively small number of highly visible tragic instances. As with our medical readiness capability, there is always room for improvement. Our very considerable efforts to improve quality assurance programs in all of our facilities will continue and will increase.

Since coming to the Department almost two years ago, I have forcefully carried on the strong commitment to quality health care made by Secretary Weinberger early on in this Administration. We have issued numerous directives covering a broad spectrum of quality assurance measures. Some of the more recent directives require licensing of military health care personnel, management of clinical investigation funds, and restrictions on off-duty employment of military health care providers.

The licensure directive, signed by July 18, requires that military physicians, nurses, dentists, and clinical psychologists have exactly the same State licenses demanded of their civilian counterparts.

A directive to be issued this month on clinical investigations is aimed at preventing conflict of interest when non-DoD funds are made available for clinical investigation services.

A second directive to be issued this month relating to off-duty employment will limit the demands placed on our military physicians in their off-duty hours and thus promote a more rested and capable provider in our military facilities.

These recent initiatives complement several earlier actions which put in place very exact standards and procedures for the credentialing of health care providers and for dealing with allegations of improper conduct or substandard patient care.

However, I am very much aware that plans are not results and that policy statements alone do not assure quality. I want to emphasize to you that these standards and procedures have been implemented and are working.

We are also looking to new and innovative techniques to directly impact upon the military medical system. Our most recent example is the unprecedented decision to adopt a program of external civilian peer review of military hospitals worldwide. This system of Professional Review Organizations (PRO's) will supplement the existing DoD quality assurance program by providing for independent review of the quality and appropriateness of care in our Military Treatment Facilities (MTFs) and Uniformed Services Treatment Facilities (USTFs) and will actually serve as a monitor of the effectiveness of our internal quality assurance efforts. We see the creation of this civilian/military partnership for military medical excellence as a giant step forward to build credibility and confidence in the quality of military health care and to ensure our quality of care is, indeed, the very best possible.

After much deliberation and consultation on this very ambitious effort, we are now well on our way toward the goal of having the PRO system in place early in 1986. A Request for Proposal has been developed and a civilian contractor will be selected this Fall. The contractor will be responsible for performing peer review of medical care in all inpatient MTFs and in the Uniformed Services Treatment Facilities starting in January 1986.

BLUE RIBBON PANEL ON SIZING

Last year, at the direction of this Committee, a Blue Ribbon Panel of distinguished civilian health care experts was appointed by Secretary Weinberger and charged with examining the methodology with which the Department sized its medical treatment facilities. Their recently completed report recognized the over-riding importance that medical readiness must have in determining the size and composition of the entire peacetime active duty medical force and of all facilities and workload in our direct care system. The Panel also advocated the establishment of firm guidelines to ensure that future facilities planning efforts be consistent with our readiness mission and listed several initiatives for improving the management of our system in peacetime.

These include:

The completion and implementation without delay of management information system currently under development, including an analytical force sizing methodology;

A survey of all DOD medical treatment facilities in order to best determine our system-wide requirements for replacement or modernization and to prioritize those requirements on a truly tri-service basis;

Shortening the amount of time it takes a medical construction project to move from the initial planning stages to final construction; and

Adopting workload measurements and other resource allocation mechanisms that reward the cost-effective provision of quality care and eliminate incentives for over-utilization of services.

Secretary Weinberger has fully endorsed the Blue Ribbon Panel's recommendations and we in Health Affairs are moving to implement all of its recommendations without delay. This implementation will result in, for the first time, coordinated and centralized management of all military medical construction, planning, and design.

DEMONSTRATION PROJECTS

A major component of our cost containment strategy involves the demonstration authority provided by Congress which permits the Department to develop and implement demonstration projects which will help to idenfify innovative methods of containing costs in the military health care system.

Already, we have taken advantage of this new authority and have projects either in place or well along in their developmental stages. At Fort Ord, California, we are using an Army facility to test the idea of giving the hospital commander complete responsibility for deciding on the most cost effective method of providing medical care to the beneficiaries residing in his catchment area. This same concept is being considered for testing at an Air Force facility, as well. A third demonstration project, this one also involving the Air Force, is designed to test the possibility of consolidating the Services' bone marrow transplant responsibilities by conducting the majority of these procedures at the Wilford Hall Medical Center in San Antonio, Texas.

In the Tidewater area of Virginia, we will be testing the feasibility of a fixed-price contract to provide or arrange for all mental health care received by our beneficiaries in the civilian community.

By testing these innovative methods of providing health care on a small scale, we hope to learn what ideas have merit and potential for cost savings which we may then be able to adopt for expansion throughout the military health care system.

OUTLOOK FOR THE FUTURE

Mr. Chairman, since coming to the Department some two years ago. I have devoted my energies to three things: improving the readiness of our medical system, the quality of care it provides in wartime and peacetime, and the cost-effectiveness of the entire system. We have made progress in all three areas, though much more remains to be accomplished. One thing that has become clear to me is that our reliance in our direct care system to accomplish both our wartime readiness and peacetime benefit mission has placed significant strains on our ability to accomplish either effectively.

Pressed by a demand to provide comprehensive health care to some 10 million beneficiaries, we have not been able to assure top priority to wartime readiness. Thus, our force structure does not meet our wartime requirements either in number or mix. Our training programs fail to adequately address these manpower priorities. Our peacetime benefit mission presents a workload that is not always relevant to developing and maintaining specialty skills necessary for wartime readiness. And, finally, civilian care services purchased under CHAMPUS are too costly and do not take sufficient advantage of competition in the civilian health care marketplace.

I believe our greatest challenges during the next several years are: first, to sort out our wartime readiness mission and our peacetime benefit mission; second, to improve substantially our ability to cost-effectivley utilize civilian health care resources to meet a larger portion of that part of the peacetime benefit demand which is not relevant to our readiness mission; and third, to accelerate the redirection of our military direct care system to effectuate our top-priority commitment to medical readiness. Meeting these challenges will likely require some departures from traditional methods of operation. If so, we will have to be ready to make such departures.

However, I want to make it very clear that we will not make a departure from our firm commitment to provide quality health care to dependents of our active duty forces and to retire members and their families. Recent press stories that this may be among our plans are not at all correct.

Quite to the contrary, one of our principal objectives as we carefully review the present state of military health care is to improve the health care benefit for our dependents and retiree families. In many areas, our present system is plagued by long delays in obtaining appointments due to inadequate staff or space to accommodate the demand. In addition, our beneficiaries who receive care from civilian providers often complain of the costs and administrative complexity of the CHAMPUS program, under which approximately 25 percent of beneficiary care is now provided.

We believe the establishment of an effective military-civilian partnership in health can reduce costs and administrative burdens and increase satisfaction for our beneficiaries and professional staff alike, as well as allow us to better achieve our readiness mission. We do not foresee a significant change in that 25 percent civilian versus 75 percent military workload split. We may, however, see a change in the type of work done in-house so that it best serves and is most relevant to the specialties and work force needed to meet our readiness requirements. We also hope to change the way we pay for the 25 percent performed in civilian facilities in order to take full advantage of the expertise and competition which now exists in the civilian community and to provide better access and continuity of care at potential savings to both the taxpayer and our beneficiaries.

Senator WILSON. Thank you very much, Dr. Mayer.

General Becker?

STATEMENT OF LT. GEN. QUINN BECKER, U.S. ARMY, THE SURGEON GENERAL

General BECKER. Good morning, Mr. Chairman and members of the subcommittee.

It is a pleasure to be here again before you.

I have a prepared statement which has been submitted, and I would like to just speak for a couple of minutes about my thoughts on the Army health care system.

We have an extremely high quality force, in great part due to the Health Professional Scholarship Programs which the Congress has given us. We have absolutely the cream of the crop of the medical students coming out of medical school.

We are totally dedicated to taking care of our troops and their families in peacetime, and certainly, as we stated last time, our primary mission is readiness to go to war and provide medical care in the event of a mobilization.

Major problems facing us today include the shortage of ancillary support. We are facing that problem right now. We have the support of the Army staff to correct this problem. It is somewhere between 5,000 and 6,000 man-years short.

We are still short a few positions in the surgical specialties. But this is improving.

We received from the Congress the capability to contract for personal services, and this has been a great help to us and we are beginning to see the fruits of this at the present time, especially in some nurse shortages that we have had in some of our medical centers.

Another major problem we have is a proper productivity measure, how we measure our productivity. The one we have is antiquated, and we are in the process of developing a new one, and we are within a few months of having it, so that we can then show that our complex procedures costs a lot more to do than the simple ones.

We also still have a problem with automation, but that is coming very fast in TRIMIS, and we will have our complete hospital system within the next couple of years.

We still have a few marginal practitioners, and we are weeding them out.

We had 28 elimination actions since May 1984. We have decredentialed and limited the activities of 29 practitioners, and in 1985, we separated 7 civilian practitioners and 4 military, and there are several others in the process. So we are cleaning that small number out.

We just had meetings with our hospital commanders and our chiefs of professional services, and I can assure you that they understand what their responsibilities are. They are reacting rapidly, now, to untoward events. You will remember some in the past, where it took some time to react. But not so now.

They are properly limiting the privileges of practitioners. They have corrected the major portion of the audit deficiencies which you referred to. Some of those that are still in progress are the long, complex ones.

We welcome a reaudit at any time now.

We do care about our patients.

Now, sometimes there are a few uncaring people, and the commanders and the CPS's understand very clearly that they are to eliminate those people or retrain them.

We are in a high risk business. We must—and I understand this very clearly—we must reduce that risk to the lowest possible level. But we will never get it to zero. We will not make zero defects in this business.

But we—and I feel very strongly about this and so does the rest of the Army staff—we owe our patients the highest possible quality care.

I thank you and I stand ready for your questions.

[The prepared statement of General Becker follows:]

PREPARED STATEMENT BY LT. GEN. QUINN H. BECKER, THE SURGEON GENERAL, DEPARTMENT OF THE ARMY

Mr. Chairman and Members of the Committee, I am Lieutenant General Quinn H. Becker, the Surgeon General of the Army. I am pleased to have this opportunity to appear before your subcommittee to discuss the Army Medical Department (AMEDD); its readiness for combat and contingency operations; and our peacetime health delivery system. I acknowledge your continuing interest and assistance to the Army Medical Department in the past and request your support in promoting our future programs.

The AMEDD is aggressively pursuing our multifaceted mission of maintaining a physically and mentally fit military force; preparing itself with equipped and trained health resources for approved combat and contingency operations; and insuring a quality peacetime health delivery program for all beneficiaries as currently authorized by law. The AMEDD system simultaneously supports these missions in its day to day operation.

I would like to thank the Congress for approving space available dental care for active duty dependents and the reduced Veterinary user fee. Both of these actions indicate the continued sensitivity of the Congress to the needs of the soldier and his family.

Of great concern to me is the recent media coverage, questioning the ability of the military health care system to provide quality health care. The focus has been on a few incidents that do not reflect the totality of the quality care being provided to our beneficiary population. The perception created by these reports is totally false. We have a good system and our Army Medical Department is made up of an exceptionally fine group of dedicated and devoted professionals who are performing in a superb manner in providing service to their patients. We are a health care system that on the average admits a patient every 1 to 2 minutes to one of our 50 hospitals; delivers a baby every 10 minutes; has 7,200 beds occupied every day; conducts, on a daily basis, 67,000 outpatient visits in these hospitals and in over 250 clinics which serve the soldier at locations away from the hospital; gives 13,000 immunizations, performs 40,000 x-ray procedures, issues 90,000 prescriptions; and generates 720,000 laboratory tests daily. In a system as large and diverse as ours we do have accidents and untoward incidents, some with tragic results, but they are by far the exception. Military medicine is not a mess. In fact, it is exceptionally good, but not good enough.

As the Surgeon General I am demanding that we insure that every practitioner is licensed and accurately credentialed. To this end we have nearly completed a 100% audit of all health care providers. As of this date 100% of active duty physicians have had their graduation from medical or osteopathic school verified. In addition to active duty, the education of physicians in the Army National Guard, Army Reserve and civilian employees are being verified. Currently, we are over 95% complete. A further verification is ongoing with a review of the American Medical Association (AMA) profile data for licensure and disciplinary action. In addition to a physician audit, the AMEDD is auditing non-physician providers. Included in this group are dentists, nurses (civilian only), optometrists, pharmacists, physical therapists, podiatrists, psychologists and veterinarians. To date, no further instances of fraudulent credentials have been discovered.

We must continue to check ourselves to insure that credentials committees act on problem practitioners. I expect that when a problem occurs in one of our medical treatment facilities I am immediately notified; that a local investigation be initiated; that the provider's privileges be suspended as appropriate; and that the quality assurance personnel act promptly. Patients and family involved will be represented by one of our hospital staff members to help them get information they need about what happened and what we are going to do about the problem. All our patients and their families are treated with respect and dignity. I expect the Commander to take prompt action on providers with suspended credentials. Based on the results of the investigation the Commander can reinstate the providers privileges, require retraining, increase supervision or initiate elimination from the military.

The provision of quality health care has the highest priority within the Army and the Army Medical Department. The current environment within which civilian and military medicine is practiced mandates a hard look at the AMEDD to determine if there are systemic problems which undermine its responsiveness to the Army family. To this end, the Surgeon General's Task Force on Health Care has been established. The Task Force is an independent agent of the Surgeon General, reporting directly to me and is vested with the authority to act on my approval on matters pertaining to the Army's health care system. Actions of the Task Force which are ongoing or complete are: the follow on verification of licensure and disciplinary action with the AMA; implemented a 100% licensure screen with the Federation of State Medical Boards; strengthen the physician accession criteria; designed the mechanism for a verified central data base of all physicians for education, licensure, graduate medical education and credentials; and added a quality assurance cell in the AMEDD personnel center to fix responsibility for record keeping.

In January of this year our quality assurance regulation was updated to include more stringent pre-credentialing and credentialing policies, procedures and reporting requirements. The update also delineates new risk management procedures and reporting policies. In the next few months we will be fielding a new automated Quality of Care Evaluation Support System which includes mortality reporting, occurrence screening, emergency room screening, and provider activity profiles. In our FY 86 budget we are requesting 115 civilian authorizations to assist with the quality assurance functions in all our hospitals. This manpower, in addition to that already in place, increased command interest, fixed responsibility throughout the chain of command, will enable the Army medical system to improve the quality of care that we already provide and is deserved by our beneficiaries.

While the AMEDD has a tremendous peacetime health care responsibility, the AMEDD is not considered just a peacetime health care delivery force. We, like the rest of the Army, must be prepared to go to war at anytime. With this peacetime force, we must be capable of making a smooth transition to a wartime posture. If deterrence fails, we must be able to provide medical support in a combat enviroment with little or no advance notice. Medical readiness has been the subject of recent reports which question the ability of the military to provide adequate health care to U.S. servicemembers in combat. These reports have painted a rather bleak picture of the current capabilities of the services. Though there is much to be done, the reports do not address the actual and programmed improvements which have taken place over the past five years.

During the early 1980s a number of actions occurred. As an interim measure, the Army reintroduced the Mobil Army Surgical Hospital to alleviate severe shortfalls in surgical care in forward areas. A medical planning cell was established in the United Kingdom to survey contingency hospital sites and receive equipment sets for five General Hospitals in support of NATO. Two General Hospital sets were forward deployed in Sagami, Japan in support of Northeast Asia. Similar efforts have taken place in Soutwest Asia. Renewed emphasis was placed on securing host nation support agreements in all theaters for critical health care delivery services during hostilities. Fully equipping all deployable medical units in both the active and reserve components became a major programming objective of the Army. Finally, the standardization effort of the quad-services, developed the Deployable Medical Systems which provide identical major components for the four Services field hospital units.

Planning for operations is conducted using the Joint Operations Planning System. Medical planners determine requirements using the Medical Planning Module (MPM). This is a subsystem of the Joint Operations Planning System. The MPM is designed to be compatible with the organization and structure of each of the Services and to recognize the unique requirements of each service.

The Medical Planning Module derives a Population at Risk (PAR) which is subdivided both by geographic operations zones and unit type. The population at risk serves as the source of daily admissions to the medical system computer by operations zone arrayed into patient classes whose number, length of stay, and death rate are determined by Service developed data. Admissions are, in turn, used to compute patient load, evacuations, bed requirements, returns to duty and other medical requirements (blood, supplies, etc.). Once the MPM data is generated the medical planner develops the type and number of medical units needed to support the plan. The Army generally plans for 1-Mobile Army Surgical Hospital, 1-Combat Support Hospital, and 2-Evacuation Hospitals (1060 total per each Division supported. This is a gross planning factor and may be modified depending on operations.

The Army computes wartime medical requirements through the Total Army Analysis (TAA) process. In this process a warfight computer simulation of the Defense Guidance Scenario is performed to determine the total theater force structure

requirement. This structure requirement is extrapolated into a manpower requirement through the use of Tables of Organization and Equipment (TOE's) which specify the number and type of personnel in each Army unit. The TOE is prepared by the medical combat developer using Army methodology and is processed through the Army Training and Doctrine Command system before receiving Department of the Army approval. All TOE's are reviewed at specific intervals to ensure that they remain valid requirement documents. The Continental United States manpower requirements are determined through a workload based process and are published in Tables of Distribution and Allowances (TDA's), which are prepared and reviewed much like the TOE's. Mobilization TDA requirements depend significantly on the workload transferred to the Continental United States from the theaters. A new methodology for determining manpower requirements for both theater and the Continental United States is being used in the Army Program Objective Memorandum for fiscal year 1988-92. The Army, like the Navy and Air Force, is using the Joint Operational Planning Systems Medical Planning Module to determine both requirements.

In 1984, the Army expanded its procurement program to fully equip 163 combat hospital units with 72,000 beds by 1991. Thirteen hospital equipment sets were purchased in 1984 for delivery in 1986-87. An additional 25 hospital sets are being purchased in fiscal year 1985 for delivery in 1987-88. The fiscal year 1986 budget request includes funding to purchase 24 more sets. Funding is also included for the modernization of division level medical units. The funding stream over several years reflects a reasonable economic level of acquisition that can be properly executed. Beginning with the fiscal year 1986 purchase, lag time for delivery will be two years rather than three years for the purchases in fiscal year 1984 and fiscal year 1985. By fiscal year 1993, all hospitals will be equipped with the Deployable Medical Systems (DMS) generation of field hospital equipment.

Growth in health provider assets has been substantial over the last five years. US Army Reserve Troop Program units have grown from 925 physicians in fiscal year 1980 to 2,325 in fiscal year 1985; the Individual Ready Reserve from 666 in fiscal year 1980 to 1,762 in fiscal year 1985. The National Guard has gone from 417 to 812 physicians. Nurses and other specialists have experienced similar growth. Physician and Nurse recruiting for the reserve components has been enhanced through flexibilty in training and service options for the medical professional while retaining a commitment in the event of mobilization. However, personnel shortfalls still exist, especially in surgical specialties, operating room nurses, and some enlisted specialites.

The Army has sufficient aggregate personnel strength to man about 82 percent of its' medical units upon mobilization. The growth realized in personnel assets since 1980 is expected to slow as recruiting concentrates now in the "hard" surgical specialities skills which are more difficult to attract. Without considering the impact of training readiness or skill qualification, sufficient personnel resources can be made available to meet battlefield health care needs of the theater, even as the enhancements in medical equipment readiness come to fruition through 1991. However, when medical personnel resources are fully allocated to the combat theater, it should be clearly understood that the Army medical support remaining in the Continental United States would be severely limited. This is attributable to personnel shortages in the remaining Continental United States base system, particularly the Individual Ready Reserve. Therefore, health care for returning casualties would rely heavily on the Veterans Administration and the National Disaster Medical System.

Since current programs will not fill existing manpower gaps, new initiatives are being researched to identify programs that will bring Reserve Component medical personnel assets to the required levels by 1992. Until such time as new programs are initiated, an alternative solution is the peacetime registration of health professionals. This appears to be the only means of meeting near term mobilization requirements given existing shortfalls in the critical skills.

Wartime training programs have been implemented throughout Army Reserve and Army National Guard medical units that are in compliance with requirements of two new DOD wartime training programs. All units are aware of their wartime alignment. All units have met or are in communication with their wartime headquarters and have received mission guidance, deployment information, and training priorities. Most units have participated in either command post exercises or field training exercises with one or more of the units that they will be associated with in wartime. More importantly, all units have plans for such exercises over the next 2 years. Early deploying Reserve and Guard units are scheduled on a three to five year cycle for overseas duty training. Also, most headquarters units have sent unit representatives to participate in command post exercises with their wartime active

components overseas. Currently, there is a system established for the peacetime chain of command to monitor wartime training and to coordinate exercises.

To further enhance readiness, active and reserve component medical personnel have been active participants in the Security Assistance Program and the AMEDD can point proudly to recent readiness accomplishments; Mobile Medical Training Teams (MTT) in El Salvador; medical support to the Regional Military Training Center in Honduras; and support of large scale training exercises in Honduras. The MTT has trained 884 combat medics, 19 senior medical NCO's, 39 medevac aidmen, 15 dental technicians, 58 intensive care nurses, and 9 biomedical technicians. In addition, they have improved the medical supply system, provided field sanitation guidance, assisted in the completion of the Military Hospital, provided combat surgery instruction, initiated a medical civic action program, participated in structuring a unified military medical system and, created a 72 man Medical Service Corps. The great need of our Central American allies for medical training and humanitarian medical support, as well as our requirement to support training of US forces, will dictate our continued AMEDD support.

An adjunct to readiness is the training of AMEDD personnel. Graduate Medical Education of our physicians ensures that there are trained physicians available to treat the medical needs of our patients. This means that infants are delivered by obstetricians and fractures are set by orthopedists. The largest source of physicians entering the Army are from the Health Professions Scholarship Program (HPSP) and the Uniformed Services University of the Health Sciences (USUHS). These physicians are not specialty trained when they enter active duty. While they are completing training they are at the same time delivering care to DoD beneficiaries. Other AMEDD personnel are trained in the Warrant Officer Entry Course, Battalion/Brigade Pre-Command Course, AMEDD Officer advanced Course, Combat Casualty Care Course, "All Corps" Basic Officer Course, and new and revised enlisted training courses.

The AMEDD's research arm, the Medical Research and Development Command, has produced some significant accomplishments, such as the development of chemical warfare agent decontamination resins for soldier/patient decontamination against mustard and nerve agents. Equally impressive is a microencapsulated antibiotic for slow release developed to control maxillofacial wound infection. The US Army Institute of Dental Research, is perfecting its synthetic biogradable, biocompatible material that will replace and repair bone loss due to trauma. Research continues in the development of a vaccine that will provide protection against dysentery. In the equipment area we are continuing to develop a field oxygen generating system, field radiographic and flouroscopic system, resuscitation devices for field use and a resucitative fluids production system which uses potable water to produce surgical and intravenous fluids that meet FDA safety standards.

While the AMEDD is fully committed to improving its medical readiness and peacetime health care, it is also actively pursuing numerous cost containment initiatives. However, to simultaneously pursue medical readiness, improve peacetime health care, and implement cost containment, requires significant tradeoffs, particularly in terms of productivity. For instance, AMEDD programs in support of readiness, such as the Over 40 years of age Cardiovascular Screening Program, physical fitness, field training and the Exceptional Family Member Program are costly to the direct care system as resources are diverted from direct care to support readiness. Also, extensive quality assurance efforts are similarly expensive and reduce resources available for direct health care delivery. Therefore, in assessing the AMEDD's commitment to these programs, it is obvious that true productivity cannot be measured exclusively in the peacetime mode. There is a balance that must be maintained between peacetime health care delivery, readiness, and cost containment which meets the needs of the Army and yet adequately reflects true productivity and the proper utilization of resources. The thrust of cost containment in the Army is the reduction of system costs within DOD by reducing CHAMPUS usage and increasing utilization of the direct care system. Many initiatives have been developed in an effort to reduce health care expenditures without reducing quality and accessibility. These include emphasis on personal services contracts, catchment area demonstration projects and CHAMPUS cost containment initiatives.

The fiscal year 1984 Defense Authorization Bill included a change which raised the statutory compensation limits and authorized the use of personal services contracts for direct health care personnel. Military physician manning levels have improved over the years due in large part to the Health Professions Scholarship Program, the Uniformed Services University of Health Sciences, and improved compensation for military physicians. However, in spite of these aims, some specialties are still in short supply. Personal services contracts will allow the services to fill physi-

cian and other health professional shortfalls through contractual arrangements. These contractual arrangements may be less costly than the alternative, which is the CHAMPUS program. An AMEDD policy is being developed that will ensure the efficient use of resources by maximizing the ability of hospital commanders to use the various available supplemental resource tools, i.e., VA/DOD Health Resource Sharing Program, Joint Health Benefits Delivery Program, and Personal Services Contracting.

The fiscal year 1984 Authorization Act gave the Secretary of Defense authority "to conduct studies and demonstration projects on the health care delivery systems of the Uniformed Services with a view to improving the quality, efficiency, convenience, and cost effectiveness of providing health care services." The Assistant Secretary of Defense for Health Affairs requested the Army to undertake a demonstration project which would combine the dollar requirements for care provided under the CHAMPUS program with the resources of the direct health care system for a particular catchment area. These resources would be placed under the exclusive control of the medical treatment facility (MTF) commander. The MTF commander would be responsible for providing all health care required by authorized beneficiaries who reside within the catchment area. A catchment area is an identifiable geographic area with a radius of approximately 40 miles. The 40 mile radius was selected to be compatible with the law which defines the CHAMPUS non-availability statement requirement for inpatient care. The site selection criteria was completed on February 1, 1985, and the MTF, Fort Ord, California, was the selected site. During September 1985, an extensive publicity campaign is being conducted and the project is to be fully operational by October 1, 1985.

The Office of the Surgeon General proposed and the Army leadership has approved the Satellite Care Clinic concept. Implementation of the Satellite Care Clinic concept is a highly visible effort to reduce utilization of the CHAMPUS program and to expand the AMEDD workbase through contracting. Under this concept, services would be provided in the community where the beneficiary population resides. This model is ideally suited to test new primary care delivery concepts in the area of patient education, patient flow, medical records, and appointment systems. The first test clinic is scheduled to become operational October 1, 1985, in the Fort Belvoir, Virginia catchment area. If successful, 10 additional clinics are scheduled to be opened between fiscal year 1987-91, giving the AMEDD 11 Satellite Care Clinics. These clinics are to be located in areas of large troop concentration with significant numbers living off the installation (Fort Bragg, Fort Benning, Fort Hood).

Another Army initiated demonstration project is under development at the MTF's at Fort Campbell and Fort Knox, Kentucky. The demonstration project proposes staffing these hospitals at fully required levels rather than minimally required as is normal. The intent is to measure the effects on workload, patient and provider satisfaction, quality of care and the cost benefit associated with increase staffing.

To achieve the goal of an Army free of the effects of Drug Abuse, the AMEDD supports combat readiness and the Army Drug and Alcohol Program by operating three urinalysis drug testing laboratories. Over the past two years, the Army urinalysis drug testing program has undergone major improvements. In January 1984, the Army began adopting a series of recommendations from a panel of legal and toxicological experts to improve the operation and forensic credibility of the drug testing program. The drug testing budget estimate for FY 86 was reduced $3.0 million. This was due, in part, because a portion of the resources required to adopt the panel recommendations were one time costs. The remainder of the decrement resulted from an assessment that the program is effectively deterring drug abuse and therefore could be called back. This reduction will reduce overall drug testing by approximately 9 percent. With some decentralization of initial screening at the installation level, and confirmation testing performed at the laboratories or under contract, drug testing will continue to be a major deterrent to drug use.

Since 1977, the Army Medical Department has continued to expand its residential treatment facilities for alcohol abuse. Currently there are 9 Army and 2 Tri-Service facilities located throughout the world. Bed capacity has increased from 100 to 300 since 1977 and approximately 1500 patients a year are treated. Almost all patients are under treatment for alcoholism, as inpatient treatment for drug abuse is increasingly uncommon. In December 1984, the decision was made that the Director of Health Services at the installation level would be responsible for quality assurance for all aspects of alcohol and drug treatment whether performed by hospitals or Community Counseling Centers which are outside the direct control of the medical facility commander. Hospital clinical consultants to the outpatient portions of the program will be the bridge between AMEDD and communities, and medical quality assurance will be applied to the entire Alcohol and Drug Abuse Program.

In conclusion, the Army Medical Department is dedicated to providing the medical care required in combat and peacetime. We are working diligently to put the mechanisms in place that will ensure we provide quality health care. The progress we have made and are continuing to make should not be overshadowed by a few isolated claims of poor medicine. The key to this system is the 72,000 dedicated officers, enlisted soldiers and civilian professionals who provide concerned care to the Army. I personally am committed to working with the Congress to see that our mutual goals are attained and that soldiers and their family receive the type of medical care they deserve.

Senator WILSON. Thank you, General Becker.

Admiral Seaton.

STATEMENT OF VICE ADM. L.H. SEATON, U.S. NAVY, THE SURGEON GENERAL

Admiral SEATON. Good morning, Mr. Chairman and members of the subcommittee.

I am, as you know, Vice Adm. Lewis Seaton, Director of Naval Medicine and Surgeon General of the Navy. I also am pleased to have this opportunity to appear before you today to discuss the Navy's peacetime health care system.

As I stated last week, the primary mission of the Navy Medical Department is to provide prompt and sustained medical support to Navy and Marine Corps fighting forces in time of war, but also to maintain the everyday health of the active force. In peacetime, we are also charged to provide a high quality health care benefit to eligible beneficiaries.

To accomplish these missions, we operate what must be considered a large medical care system, based on 31 hospitals with a total capacity of over 4,000 beds. Our practitioners see approximately 13 million outpatients, and admit over a quarter of a million inpatients each year. This system is staffed by about 4,000 medical officers, 3,000 nurses, 1,700 dentists, 2,300 medical service corps officers, 25,000 enlisted personnel, and 10,000 civilians.

The size of the Navy health care system is based upon the requirements of the wartime readiness mission.

Our stateside hospitals have a dual primary purpose—namely, the medical care of active duty personnel along with providing an immediately available source of active duty medical forces that can be deployed quickly in case of war, disasters, or other contingencies that might arise.

Naval medical manpower is planned and programmed to meet wartime requirements. But it is the utilization of this active duty medical force in peacetime to provide care for nonactive duty beneficiaries that support both the readiness and the health benefit mission by allowing the health care providers to constantly maintain their medical and surgical skills. Included in the proposed fiscal year 1986 budget is a manpower level necessary to satisfy both wartime mission and peacetime readiness requirements.

The manner in which this active duty manpower is distributed amongst facilities during peacetime is dependent upon several considerations. Some factors which influence the size, staffing, and services provided by our stateside facilities include beneficiary population projections, historical demands for particular services, support for training requirements, availability of local civilian facilities, and some mission unique requirements for Navy and Marine

Corps personnel. We coordinate planning with the other services, the Veterans' Administration, and civilian health planning agencies to ensure that use is made of existing facilities and that services and facilities are not unnecessarily duplicated. I believe the near future holds intensified efforts in this area of planning coordination.

Demonstrating one important example of the linkage between our mobilization capability and the peacetime health care system is the organization and use of what we term mobile medical augmentation readiness teams [MMART].

The various types of MMART teams, surgical teams, surgical support teams, disaster teams, nurse teams, special psychiatric teams, serve as units of trained medical department personnel, functionally organized and capable of immediately augmenting Navy and Marine Corps operating forces for limited military operations, disaster relief missions, and routine fleet exercises. Since their inception MMART teams have actively participated in operational assignments, including Beirut, Grenada, and other forward deployed missions. These teams are kept on a rotating 48-hour alert at their parent hospitals, and are fully capable of going from their active peacetime health care roles to worldwide deployment in a matter of hours.

Dedicated personnel of all types; officer, enlisted, civilian, both Active and Reserve, are our most critical asset. Over the last several years, the Navy has concentrated on efforts to achieve the right numbers and mix of personnel. We have met our authorized physician end-strength for the third straight year, but problems still remain with physician specialty mix. Programs to correct this deficiency over the next few years include targeting recuiting goals for physicians trained in the undermanned specialties, active duty deferrals for scholarship students in those undermanned specialties, developing specialty substitution criteria, and implementing new programs to attract, train, and retain Reserve personnel.

The delivery of quality care of the operating forces and other eligible beneficiaries is the top priority of the Navy Medical Department today. A year ago, we refined and reissued our comprehensive quality assurance instructions to: incorporate more stringent requirements; to further strengthen the credentialing process for health care providers; streamline the administration of existing programs; and include even more exacting quality assurance procedures. Today, all of our naval hospitals are accredited by the Joint Commission on the Accreditation of Hospitals.

Although the goal to shoot for has always been the delivery of high quality medical care without a single adverse incident, a system as large and diverse as this is likely to have isolated cases of individual substandard care. When the enormous number of beneficiaries receiving care each year is compared to the small number of regrettable cases of adverse outcome, we have an excellent record of high quality of care rendered.

Whenever our quality assurance system identifies substandard provider performance or a substandard process or practice, we act immediately to zero it out with actions ranging from counseling, remedial training, withdrawal or restriction of individual privileges and administrative separation from the service to the full range of

disciplinary actions, including court-martial. The directive on health care provider conduct is now in force and specifies the actions which must be taken when allegations of misconduct or substandard care are made. Promptness of response to allegations is given high priority.

With the directives governing hospital-based quality assurance systems as a guide, a lot of effort is being directed to refining quality assurance programs in the operational forces. We have issued new directives which require compliance with credentialing and quality assurance standards that parallel those in our hospitals but are tailored to operational forces use.

Under no circumstances will substandard care be condoned. Patient hotlines are available at all facilities for registration of complaints directly to the commanding officer. A rigorous process has been established that commanding officers must follow upon allegations of misconduct of any kind on the part of a health care provider.

I believe our record shows that we have taken decisive action to identify and correct cases of poor quality care. The Navy Medical Department quality assurance system is of the highest caliber and underscores the resolve of the Navy Medical Department to provide quality care to all of our beneficiaries.

Mr. Chairman, I am confident that we have designed and developed a responsive, comprehensive health care system that meets our wartime requirements while at the same time providing a high quality health care benefit in peacetime. With your continued support, coupled with the dedication of the personnel of the Navy Medical Department, we will continue to provide the best overall quality military medical care available anywhere in the world today.

I would be pleased to answer any questions you may have.

[The prepared statement of Admiral Seaton follows:]

PREPARED STATEMENT OF VICE ADM. LEWIS H. SEATON, MEDICAL CORPS, USN, DIRECTOR, NAVAL MEDICINE AND SURGEON GENERAL, DEPARTMENT OF THE NAVY

Mr. Chairman and members of the subcommittee: I am Vice Admiral Lewis H. Seaton, Medical Corps, United States Navy, Director, Naval Medicine and Surgeon General of the Navy. I am pleased to appear before you today to discuss the Navy's peacetime health care system. I would like to begin with a description of the mission, organization, and structure of the Navy Medical Department followed by a discussion of the initiatives we have undertaken to ensure that our beneficiaries receive quality care.

The mission of the Navy Medical Department is to provide prompt and sustained medical support to Navy and Marine Corps operating forces in time of war, to ensure health maintenance of the active force, and to provide a high quality health care benefit to authorized beneficiaries in peacetime. To accomplish this mission, we operate a large medical system which provides care ranging from that delivered in a sickbay by a single independent duty corpsman to sophisticated state-of-the-art treatment rendered by a multi-disciplinary team in large tertiary care facilities.

The Navy medical system includes 31 hospitals with an aggregate capacity of over 4,000 beds, 158 branch medical clinics, and 172 dental clinics. This year we will see about 13 million outpatients, admit over 250,000 inpatients, deliver 34,000 babies, and perform 150,000 surgical operations. The performance of these tasks requires 4,000 medical officers, 3,000 nurses, 1,700 dentists, 2,300 administrators and allied health scientists, 25,000 enlisted personnel, and 10,000 civilians.

The structure of the Navy Medical Department falls into three major organizational levels. My office (Office of the Director of Naval Medicine) is part of the staff of the Chief of Naval Operations and is responsible for policy and program develop-

ment, resource planning and programming, and oversight of the Navy medical system. The next echelon, the Naval Medical Command, Washington, DC, is responsible for program execution, professional and technical guidance, and professional development. Our field activities are organized into broad geographic regions—six in the Continental United States (CONUS), one in the Pacific area, and one in Europe. These geographic medical commands have command authority over the individual medical and dental treatment facilities operating in their respective areas.

REQUIREMENTS FOR PEACETIME HEALTH CARE

The size of our health care system is based upon the requirements of our wartime readiness mission. To support that mission, we have developed a CONUS-based hospital system which has as its primary purpose the provision of medical care to the active duty force. It also serves as the mobilization base for meeting wartime personnel requirements. The CONUS health care system provides an immediately available active duty medical force that can be deployed quickly in wartime or other contingency to support Navy and Marine Corps combat forces in the theater of operations. In wartime, CONUS hospitals will treat casualties expected to be returned to duty to support force sustainability, serve as casualty receiving, sorting, and distribution centers for casualties evacuated from the combat area to the United States, and provide care in areas with large concentrations of active duty personnel. Each of these requirements dictate the construction, size, and maintenance of our medical treatment facilities.

There are also certain aspects of the military health care system which are unique to the Navy's wartime requirements. The delivery of health care in submarines and surface ships, in aircraft, and on land with Marine forces are factors unique to Navy medicine which are considered when developing requirements and capabilities for our health care system.

In addition to the operational support requirements, other factors which influence the size, staffing, and services provided by the CONUS hospital system include beneficiary population projections, historical demands for services in a particular catchment area, support for graduate medical education programs, availability of civilian facilities, and mission-unique requirements for Navy and Marine Corps personnel. The workload and cost benefit of providing medical services in-house rather than under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) are evaluated in developing sizing and staffing criteria. We coordinate our facility planning efforts with the other Services, the Veterans Administration (VA), as well as civilian health planning agencies to ensure that maximum utilization is made of existing facilities and that services and capabilities are not unnecessarily duplicated.

Sizing determinations are based on demographic data such as present and projected patient populations within each beneficiary category and on present and historical workload data. The ages of active duty personnel are considered, as well as the number of female active duty, number of females within the child-bearing age group, the number of married active duty members, and the estimated number of dependents per military sponsor. Utilization rates within each beneficiary category for inpatient and outpatient care are also considered when projecting future facility requirements.

Our manpower capabilities are programmed to meet our documented wartime requirements. Manpower assets must be in place in the event a contingency occurs. The use of the active medical force in peacetime to provide care for non-active duty beneficiaries supports the readiness and health benefit missions and allows health care providers to maintain their medical skills. Overall endstrength allowed Navy for military personnel is provided by Congressional authorization and appropriation. Staffing for military medical facilities must fall within the medical department's share of that overall endstrength. As a consequence, staffing for individual Navy medical facilities is to a large degree a process of allocation of authorized manpower in the most effective and efficient manner. Factors included in determining individual facility allocations include: historical workload; projected populcation changes; facility configuration; mission orientation of active duty forces supported; training requirements; and recapturable CHAMPUS workload.

Staffing allocations will vary when population or mission changes can be documented such as, the assignment of new operational units, or when other programmatic changes occur. For example, increases budgeted to support programs like internal review, quality assurance, family advocacy, or occupational health and safety would be allocated to facilities for those specific purposes. We have included in the

proposed fiscal year 1986 budget the manpower level necessary to carry out our wartime mission and peacetime readiness requirements.

An important aspect of Navy's peacetime health care system is the organization and use of Mobile Medical Augmentation Readiness Teams (MMART). The mission of the MMART is to serve as a unit of trained medical department personnel functionally organized and capable of immediately augmenting Navy and Marine Corps operating forces for limited, short-term (less than 180 days) military operations, disaster relief missions, the fleet exercises. These teams are composed of active duty physicians, dentists, nurses, medical service corps officers, and hospital corpsmen representing various specialty categories. The nucleus of the MMART program is the surgical team. Since their inception, MMART teams have actively participated in operational assignments with recent operations including Beirut, Grenada, and other forward deployed missions. These teams are kept on a rotating 48-hour alert at their parent commands and all are fully capable and ready to deploy worldwide on short notice. Deployments of these teams must be taken into account in determining the size of medical facility staffs because personnel assigned to MMART teams for fleet deployment and operational exercises are taken from our direct health care system. In fiscal year 1984, over 78 manyears were subtracted from the capacity of the direct health care system through the deployment of these teams. We solicit your support for our fiscal year 1986 manpower request in order to have the personal necessary to maintain the combat readiness of our medical force while operating an extensive health care delivery system.

Although we have met our authorized physician endstrength for the third straight year, problems still remain with our physician specialty mix. We do have programs in place that will correct them over the next few years. In the past two years, recruiting goals for physicians have been targeted toward critical and undermanned specialties such as anesthesiology, orthopedics, and surgery. Maximizing the number of positions in Navy residency programs, sponsorship of people in civilian training, and judicious use of active duty deferrals for our scholarship students are initiative we have undertaken that are focused on the critical specialties. To aid in eliminating the differences in physician specialty mix requirements in peacetime and wartime, we have developed specialty substitution criteria whereby physicians can be assigned to other clinical specialties. For example, in wartime, pediatricians can be assigned to fill primary care medical officer requirements and obstetricians can be utilized to meet some general surgery requirements.

In addition, we have made significant achievements in the development of new flexible reserve component programs designed to attract and retain key surgical specialists in order to meet time-phased contingency requirements.

The Physician Reservists in Medical Universities and Schools (PRIMUS) program allows members to receive drill credit for certain specific designated medical activities that the PRIMUS officer certifies to be mobilization enhancing. Navy has authorized PRIMUS units at 37 universities. The Reserve Flexibility (REFLEX) program permits reservists to accrue drill credit on an hour-for-hour basis for equivalent medical training related to their wartime medical duties. REFLEX is designed to accommodate the demanding personal schedules of medical specialists in the reserve forces. This opportunity has been extended to all Naval reserve physicians.

The Navy's Sea and Air Mariner (SAM) program is the key to recruiting the required number of basic hospital corpsmen (HM's) into the Naval Reserve. These recruits attend recruit training and Class "A" Hospital Corps School and then return to their communities as drilling reservists. In fiscal year 1986, the SAM program will access about 2,500 HM's (1,800 "A" school graduates and 779 Reserve Allied Medical Program technicians). This program includes authority to enlist graduates of Navy approved civilian medical technical schools in advanced pay grades. This will help in our efforts to recruit into the reserves people with advanced skills such as operating room technicians, clinical laboratory technicians, and x-ray technicians.

Through the Mutual Support Program, our reserves have provided the Navy with an increased level of health care services while training in our facilities to prepare for their mobilization role. During fiscal year 1984, reservists served more than 8,000 man days under this program. More than double that amount will be provided in fiscal year 1985.

Our recruiting efforts, specialty substitution criteria, and reserve initiatives are starting to have the desired, positive effect on correcting our specialty mix problem.

QUALITY ASSURANCE IN NAVAL MEDICINE

Health care quality assurance in the Navy applies to every patient and every provider. It is a Navy-wide system to monitor and evaluate the quality of care provided to all our beneficiaries. While the purpose of this program is to identify and correct problems, it has overwhelmingly documented that the quality of care we provide to those we serve is excellent.

After the Joint Commission on Accreditation of Hospitals (JCAH) introduced its Quality Assurance standard, Navy's first quality assurance (QA) instruction was issued in 1981 and was refined and updated in 1984. Since the program's inception, credentialing guidelines, one of the cornerstones of the program, have been continually strengthened. Currently, the Navy credentialing process is one of the most stringent which exists in the American health care system. These advances in credentialing are only one example of improvements in our overall QA system.

A year ago we re-issued the comprehensive quality assurance instruction, which markedly improved and strengthened the entire QA process. This refined QA guide incorporates 4 years of indepth experience at all levels of health care, plus yearly updates of the JCAH standards, and Department of Defense directives. The result is a streamlined program which not only meets but in many cases exceeds JCAH requirements.

Attaining JCAH accreditation is part of the mission statement of our hospitals and large clinics and we have been very successful in achieving this goal. All of our naval hospitals and eleven large clinics are JCAH accredited. JCAH surveys are conducted at each facility every 3 years. Accreditation requires facilities to meet very strict requirements for quality assurance, medical staff standards, records review, and building and safety standards. We stand ready to fully cooperate with other external civilian peer review as directed. Our successful record with the JCAH documents the care we provide meets or exceeds national standards.

As stated earlier, the credentialing process is one of the cornerstones of our quality assurance programs. Current directives address every aspect of credentialing, from accession to separation, and notification of the Federation of State Medical Boards regarding decredentialed physicians. Similar notification is also required for dentists and nurses. A provider is recredentialed every 2 years based on demonstrated clinical competence. This rigorous program stipulates:

Strict requirements for verification of credentials prior to accession.

Individuals' credentials files must accompany providers throughout their career.

Temporary privileges be granted and proctoring be required at a new duty station prior to granting defined permanent privileges.

Privileges must be provider and hospital specific.

A provider's current clinical competence, based on monitoring and evaluation, must be addressed at the time of recredentialing.

A fair hearing (due process) is required in cases of adverse credentials action.

Adverse credentials action against providers may include temporary or permanent limitation, suspension, or revocation of clinical privileges.

Providers separated from the Navy with lost or limited privileges be reported to licensing agencies.

Credentialing requirements apply to all providers, including operational units, and reserves.

If we identify substandard provider performance, we are required to take immediate actions ranging from restriction of privileges to separation from the service. A new instruction on health care provider conduct has been implemented which specifies a commanding officer's accountability and the actions which must be taken when allegations of misconduct or substandard care are made. Where there is evidence that patient safety is jeopardized, the provider's privileges are suspended and notification thereof is forwarded to the Director, Naval Medicine and Assistant Secretary of Defense for Health Affairs. When the command's investigation indicates that suspension is not warrranted, the Commanding Officer must express his confidence in the provider's competence and provide written notifications to the individuals indicated above.

To further strengthen our QA programs, we have implemented occurrence screening in our hospitals. This procedure, widely used and accepted in the civilian community, monitors the occurrence of a number of potentially adverse events as a method to identify providers or processes which cause instances of less than acceptable standards of care. Our first report on aggregate data was submitted to the Assistant Secretary of Defense for Health Affairs in April 1985. In addition to the required 18 hospital-wide generic occurrence screens, we have participated in tri-service working groups to develop similar screens for emergency medical services and

obstetrical services. At this time, all department heads have been instructed to formulate and monitor specific screens for each clinical service. We are also developing occurrence screening procedures for outpatient clinics. This process is manpower intensive and will require significant automated support for full implementation. We are working closely with the Tri-Service Medical Information Systems Project Office to develop an automated QA support system which should be in place by January 1986. Our requested fiscal year 1986 manpower increase will aid our QA efforts.

Although one of our primary goals in our direct health care system is the delivery of high quality medical care without any adverse incidents, in a system as large and diverse as ours, isolated cases of substandard care are likely to occur. Our QA sysem is effective and identifies such cases. However, when the enormous number of beneficiaries receiving care is balanced against the small number of problems, we have relatively few exceptions to the high quality of care rendered.

Now that our hospital-based QA systems are in place, we are concentrating on improving our programs in the Fleet. The past 6 months has seen a dramatic increase in the resources dedicated to quality assurance efforts in the operating forces. New instructions require credentialing and quality assurance systems which utilize the same rigid criteria, including occurrence screens, employed in our hospitals. As we had done previously for our fixed medical treatment facilities, we have issued new instructions requiring rigorous supervision and monitoring of non-physician health care providers in the operating forces.

The new guidelines clearly delineate duties for and improve management of physician assistants, nurse practitioners, and independent duty corpsmen when they act as primary care providers. Responsibilities and limitations on these groups are specifically defined. The instructions allow for more effective use and greater stability and support for these important members of the health care team.

Quality assurance is a system to monitor the health care we provide. Our program to provide quality health care is dependent upon the recruitment and retention of highly trained, dedicated health care providers. Under current policy, physicians entering into the Navy Medical Corps undergo an extensive review of their professional qualifications, education, licensure, prior credentialing, and references prior to commissioning in the Navy.

Each applicant must be a graduate of an approved school of medicine or osteopathy. Similarly, other health care providers (dentists, nurses, psychologists) must possess an equivalent degree in their specialty. Creditials are verified and then reviewed by a professional officer accession board. While the majority of our practitioners currently possess a valid state license, this will be mandatory in July, 1988.

Once recruited, our personnel participate in a variety of training programs to maintain professional competence. Physicians attend professional meetings within their specialty, perform on-the-job training under the tutelage of recognized experts in their field, and provide similar training for their peers. Through special arrangements, the Navy has provided continuing educational opportunities with other federal health agencies as well as selected civilian institutions.

The quality of care we provide is absolutely a top priority of the Navy Medical Department. Never before have we expended as great a proportion of our effort to ensure this goal is achieved.

The above initiatives demonstrate our commitment to the delivery of the highest quality care. Under no circumstances is substandard care condoned. Patient hot lines are available at all facilities for registration of complaints directly to the commanding officer. A carefully laid-out process has been established that commanding officers must follow when there are allegations of misconduct of any kind on the part of a health care provider. We have taken decisive action to identify and correct cases of substandard care. The dedication of our providers to the principles of this program underscores the determination of the Navy Medical Department to provide the best available treatment to all our beneficiaries.

DIRECT HEALTH CARE DELIVERY SYSTEM

We continue to pursue specific management initiatives to increase the effectiveness of the direct health care system. One of our specific goals is to maintain the reduction in the number of Certificates of Nonavailability (CNA's) issued for inpatient care under CHAMPUS. During fiscal year 1984, we exceeded our goals in reducing CHAMPUS referrals by issuing 17 percent fewer CNA's than in fiscal year 1983. All naval medical commands have been assigned fiscal year 1985 productivity goals to increase admissions, average daily patient load, births, and outpatient visits.

Other new initiatives, recommended by our own internal audits, have streamlined the medical board system. Two different areas were revised; one reducing the number of limited duty boards and the other expediting the disposition of long-term care patients.

In April 1984, we published new guidelines which allow for assignment of up to 12 months limited duty and return to full duty without the necessity of another medical board. This process prevents assignment of personnel to limited duty for longer than necessary and reduces lost time to the fleet. The elimination of unnecessary medical boards also reduces workload at our treatment facilities. Since its implementation, we have seen a 14 percent decrease in the number of medical boards, shorter periods of limited duty, and better working relationships between the medical department and line commands at all levels.

Changes in procedures for management of long-term care patients mean that these patients are no longer delayed from disposition to Veterans Administration hospitals because of requirements for complete medical board processing and line-of-duty determination.

Our initiatives to improve productivity and bring CHAMPUS workload back in-house will continue to reduce overall medical care costs. These initiatives, along with our manpower-intensive quality assurance program, will require our budgeted manpower increases.

SUMMARY

In summary, I am confident that we have developed a comprehensive health care system that meets our wartime requirements while providing a high quality health care benefit in peacetime. The quality of care that is delivered is excellent today and will remain so in the future with quality assurance systems to ensure excellence. Individual cases of unsatisfactory performance should be judged on the basis of the entire set of facts surrounding each case and the timeliness and appropriateness of corrective and disciplinary actions taken in each instance. Your support of our programs is crucial to our capability to meet our mission requirements.

Senator WILSON. Thank you very much, Admiral Seaton.

General Chesney, may we hear from you, please.

STATEMENT OF LT. GEN. MURPHY CHESNEY, U.S. AIR FORCE, THE SURGEON GENERAL

General CHESNEY. Good morning, Mr. Chairman.

I would like to put my entire statement in the record.

However, there is one thing that came out of last week that I would like to address very briefly.

In the discussion of the Zimble Commission and the Beirut bombing, the impression was left that the Air Force bypassed Army hospitals and took all patients to the Air Force Hospital at Wiesbaden.

For the record, I would like to note that the C-9 which left Beirut at 3:12 in the afternoon for Rhein-Main took 13 patients to the Air Force hospital at Weisbaden and 10 patients to the Army hospitals at Landstuhl and Frankfurt.

The second plane, which left 7 hours later for Rhein-Main, had 13 patients and 3 of those went to the Air Force hospital at Wiesbaden, and 10 to the two Army hospitals.

So, of the 36 patients that we transported to Germany for care after the Beirut bombing, the Air Force got 16 and the Army got 20 of those patients.

I would be happy to answer any of your questions.

Thank you, sir.

[The prepared statement of General Chesney follows:]

PREPARED STATEMENT OF LT. GEN. MURPHY A. CHESNEY, THE SURGEON GENERAL, U.S. AIR FORCE

Mr. Chairman and Members of the Subcommittee. I am Lieutenant General Murphy A. Chesney, Air Force Surgeon General. I am pleased to have the opportunity to discuss the Air Force health care system and our peacetime structure with you.

In peacetime, we operate a three-tier medical system, ranging from clinics, to community and regional hospitals, to major medical centers. Within this framework, we operate 6 medical centers, 77 hospitals, 41 clinics and 73 medical aid stations around the world, interfacing with the aeromedical evacuation system.

The following chart shows our current staffing:

Corps	Fiscal year 1985 authorized	June 30, 1985 assigned	Percent of authorized assigned
Medical	3,867	3,831	99.1
Dental	1,598	1,566	97.9
Nurse	4,862	4,854	99.8
Biomedical sciences	2,324	2,258	97.2
Medical service	1,186	1,206	101.7
Enlisted	28,847	27,176	94.2
Total	42,684	40,891	96.0

We comprise approximately 26% of the Department of Defense (DOD) health care budget, have 31% of active duty personnel and 31% of hospital beds, offering a comprehensive range of health care services to nearly three million beneficiaries worldwide.

Our services run the gamut from prenatal care for expectant mothers to geriatric care for our aging retirees; from environmental issues to man in space; from health education to readiness field training. We provide all the major specialties of American medicine. The needs of our beneficiaries are met primarily through the direct care system, if available, or in the civilian system for active duty personnel covered by supplemental funds, or under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) for retirees and dependents if the needed service is not available in military health care facilities.

The Air Force Medical Service fiscal year 86 budget is $2.5 billion. This supports our peacetime operations and maintenance requirments. It provides for the education and training of our personnel, the Health Professions Scholarship Program, the clinical investigation program, peacetime operation and maintenance of the aeromedical evacation system and the construction and maintenance of our hospitals and clinics.

Our funding requirements are scrutinized very closely at several levels within the Air Force command structure to be sure they represent the minimum level for the efficient peacetime operation of our health care delivery system. We continually look for ways to reduce or limit cost without jeopardizing the quality of medical care we deliver.

The Air Force Medical Service places high priority on containing DOD health care costs, stimulating management innovation and improving accessibility to our health services.

We have been successful in containing health care costs by negotiating sharing agreements with 36 Veterans Administration (VA) facilities. These agreements range from routine diagnostic services to complex surgical procedures which enable both the VA and the Air Force to more effectively use their health care resources.

Recently, we took a bold step in sharing with the VA. A new hospital proposed for construction at Nellis AFB, Nevada, will be a joint Air Force/VA hospital. This project, which is still under development, will benefit both Air Force and VA beneficiaries in the Las Vegas region of Nevada.

Right now, the VA has only an outpatient clinic. With the completion of this proposed 135-bed facility in the early 1990's, inpatient care will be available for the Air Force beneficiaries and the growing veteran population.

At 15 of our bases, we have approved the granting of staff privileges, under the Joint Health benefits Delivery Program, to civilian physicians representing 24 specialties. When these physicians admit a patient to our facilities, professional fees

are paid by CHAMPUS and there are no institutional charges. The average CHAMPUS cost expected for an inpatient admission is reduced by 80%.

In fiscal year 1984 we opened or expanded 22 medical services at 19 locations. In fiscal year 1985 we expect to open or expand 29 more. Some of the service expansion will result from contracting and others from military staffing improvements.

In addition to enhanced military staffing, sharing agreements, Joint Health Benefits Delivery Program and contracting, we are striving to improve accessibility by automating our appointment systems and expanding clinic hours. Thirty-two percent of our hospitals and thirty percent of our clinics hold regular after hours clinics.

A paramount goal of the Medical Service is to increase the availability of military medical services, thereby, reducing CHAMPUS costs. Our major thrust to recapture CHAMPUS workload was begun in fiscal year 1982. At the end of fiscal year 1984, Air Force hospitals had increased clinic visits in excess of 1.1 million, bed days in excess of 60 thousand, and births had increased close to 5 thousand. Over that same period, 39.4% fewer certificates of nonavailability were issued (certificates of nonavailability authorize beneficiaries to use CHAMPUS when military hospitals lack needed health services). These certificates of nonavailability, had they been issued, would have cost CHAMPUS approximately $57 million. We have also expanded dental services. Since July of this year, we have been able to provide dental care for dependents on a space available basis.

Looking toward the future, Wilford Hall USAF Medical Center, Lackland AFB, Texas, our largest medical facility, will be the test site for a five-year demonstration project for bone marrow transplants within the DOD. Beginning this October, all persons requiring bone marrow transplantation and eligible for CHAMPUS health benefits will be referred to Wilford Hall. Combining the expertise of a central Air Force medical facility with CHAMPUS money is expected to save DOD 40–60% of current costs and reduce health care costs to beneficiaries.

We are planning a three-year catchment area demonstration project to begin in calendar year 86 at USAF Hospital Nellis. In this project the hospital commander will be responsible for managing the provision of all health care to military beneficiaries in that area. CHAMPUS monies will be transferred to the hospital commander for use in this project. As with the Wilford Hall project this is expected to result in lower health care costs, for both the government and beneficiary.

We are seeking modernization of Air Force medical facilities to provide health care in Air Force catchment areas in the most cost-effective manner. To this end, we recently proposed to replace the antiquated and inefficient hospital at Malmstron AFB, Montana, with a modern, composite medical facility including a comprehensive ambulatory care clinic and 30 inpatient beds. This proposal was not approved, instead an ambulatory care clinic with eight holding beds was suggested.

A preliminary estimate of the impact this proposal has on the Malmstrom area, suggests that Air Force beneficiaries will have to absorb an increased out-of-pocket cost of $2.5 million annually plus an increased government cost of approximately $5.5 million annually. This analysis indicates that replacing the hospital would be the most cost-effective approach over the life cycle of the facility. Nevertheless, we are proceeding with this smaller facility because replacement of the existing facility is urgently needed due to its poor condition.

QUALITY OF CARE

I wish to assure the members of this subcommittee that the Air Force Medical Service is providing high quality care. A few tragic incidents that occurred in military hospitals have been highlighted by the public media and generalized to the conclusion that all military medical care is bad. Let's view our service in perspective. In fiscal year 1984, the Air Force Medical Service recorded 16,811,259 clinic visits, 282,019 hospital admissions, 3,592,799 dental visits, 38,262 live births, 27,298,597 prescription issues, 6,048,813 x-rays taken and 393,756 physical examinations given. Out of the millions of patients treated, 263 malpractice claims were filed.

Regarding legislative efforts to modify the *Feres* Doctrine, we agree fully with the position expressed by the DOD General Counsel and oppose such initiatives.

I regret that medical malpractice has and does occur in Air Force health care facilities and I am committed without reservation to minimizing and, if possible, eliminating such occurrences. However, the best method for minimizing medical malpractice and improving the quality of health care is through our active quality assurance program.

Although I do not like to make comparisons with civilian medicine, those are the standards against which we are judged. Since 1979, when the Air Force instituted

its risk management program, annual Air Force malpractice claims through 1984 have decreased 13% (302 to 263). During the same period, annual civilian malpractice claims have increased 114.2%. All Air Force hospitals which have sought accreditation from the Joint Commission on Accreditation of Hospitals (JCAH) have been accredited. Annually, approximately 2% of civilian hospitals that seek accreditation fail to achieve it. Another indicator of quality of care in Air Force hospitals is that the noneffective rate (the number of active duty personnel per 1,000 not available for duty on any given day due to illness or injury) decreased from 16.1 per 1,000 in 1950 to 3.5 per 1,000 in 1984.

In general, graduates of Air Force residency programs have a higher success rate on board certification exams than the overall national average.

There are many indicators of the quality of personnel in the Air Force Medical Service. For example, the Air Force Urology Residency Program at Wilford Hall USAF Medical Center, was ranked number one out of 137 programs nationwide last year by the American Board of Urology. This is the second number one ranking, and the third time the program ranked within the top five during the past four years.

Every 1984 graduate (100%) of Air Force Internal Medicine Residency programs who took the certifying examination in internal medicine passed. The pass rate for all takers was 58%. The pass rate for first time takers who are graduates of United States and Canadian medical schools was 85%. Nationally, 387 programs had residents who took the board examination in 1984. Of those programs, David Grant USAF Medical Center, Travis AFB, California residents scored in the 85th percentile, USAF Medical Center Keesler, Keesler AFB, Mississippi residents scored in the 91st percentile, USAF Medical Center Wright-Patterson, Wright-Patterson AFB, Ohio residents scored in the 95th percentile, and Wilford Hall USAF Medical Center residents scored in the 98th percentile. This attests not only to the quality of our personnel, but also to the quality of our teaching programs.

We have taken numerous actions to ensure that we provide quality care. A quality assurance office was established in 1983 with primary responsibility for overseeing medical quality assurance/risk management (QA/RM) and credentialing at the Air Staff level. It has been instrumental in developing, coordinating, and implementing a new approach to internal control review: the combining of QA and RM activities into the improved Air Force quality assurance/risk management program.

In addition to the QA office which was established on my staff, each major command surgeon has designated his Director of Professional Services as the command QA coordinator. I also directed that each facility assign an officer as a full time QA coordinator. (These officers were assigned from existing resources.)

During the period when the mechanisms of our QA program were new and evolving, several audits were conducted. These audit reports identified administrative record-keeping problems in our QA programs. Most of these findings had been noted previously by the Air Force Inspector General. A definitive QA regulation was published in May 1984. It expanded guidance on credentialing, morbidity and mortality review, and ancillary services reviews. It provided detailed guidance on operating an extensive QA program. It requires comprehensive QA efforts by the medical staff. The procedures in this regulation have been expanded to give better guidance on investigating, suspending, or terminating privileges. Additionally, a new conditional privilege period was implemented which requires any physician or dentist, who is decredentialed in the first 365 days of active duty, to be immediately separated from the service. It gives explicit guidance on how to conduct hearings and on the appeal process. It requires that the Surgeon General be notified within 48 hours when action is taken to investigate, suspend, or terminate privileges. It gives guidance on how to deal with impaired providers and it requires that the state licensure agency be notified when any practitioner separates from the Air Force in a decredentialed status.

These new guidelines have worked. Since 1980, the following number of practitioners have been decredentialed for each year noted: 23 in 1980, 38 in 1981, 33 in 1982, 18 in 1983, 68 in 1984, and 53 in the first half of fiscal year 1985.

We have directed that specific attention and guidelines be applied to the initial recruitment and accession of health care providers so that medical personnel screening and selection are improved. The Air Force, along with the other Services, is currently establishing procedures to have appropriate automated screening and other verification checks accomplished at least annually for their physicians. The Health Professions Recruiting Directorate of the USAF Recruiting Service has also been requested to perform appropriate licensure checks with the Federation of State Medical Boards, the American Medical Association, and the Drug Enforcement Adminis-

tration on all physician accessions entering the Air Force through recruiting channels.

There has been recent discussion regarding licensing of physicians and other health care providers. The DOD and the military Services have jointly developed a new DOD directive which requires all physicians, dentists, nurses and clinical psychologists to be licensed within three years. Maintaining a current license will become a part of the practitioner's credentials files which is closely monitored.

We have established clearly defined criteria for monitoring quality assurance indicators at the local medical treatment facility and for identifying and determining a practitioner's skills. At the heart of these efforts is inpatient occurrence screening, a quality assurance assessment technique that identifies specific, potentially important, unexpected events of treatment to ensure timely review and analysis of clinical cases. The Air Force successfully tested this technique and proposed it to the Office of the Assistant Secretary of Defense for Health Affairs, who later mandated its use in military hospitals.

To handle the voluminous administrative tasks imposed by the QA program, we requested approximately 200 additional personnel. We did not get the number requested but, in October this year, we will begin acquiring 141 personnel who will be dedicated solely to the QA effort. Most of them will be performing the tasks involved in documenting credentialing, and various other record keeping requirements.

Automated data systems are critical to our continued progress. The Automated Quality of Care Evaluation Support System (AQCESS) is an automated QA support system to be installed in 82 Air Force hospitals that will provide microcomputer assistance for DOD mandated QA/RM programs. This includes medical treatment facilities-wide provider credentialing and profiling, occurrence screening management, QA problem activity tracking, and incident report analysis. AQCESS will vastly improve the quality and timeliness of the evaluation of health care.

STAFFING MILITARY MEDICAL FACILITIES

The Air Force Medical Service has developed a planning model called PRISM (Provider Requirements Integrated Speciality Model) to determine long-range requirements for medical manpower. PRISM is divided into three parts. PRISM I determines the selected provider mix required to provide a balanced community health program, limited to current provider authorizations. PRISM II determines the number and specialty mix of providers for our contingency requirements. PRISM III determines the number and specialty mix of selected providers required to provide health care for the beneficiary population within the service area of each medical treatment facility.

PRISM is used to plan medical care provider requirements for each of the USAF medical treatment facilities throughout the world. This model provides Air Force medical planners and decision-makers with a tool to determine the facility-specific peacetime health care requirements of Air Force medical facilities and the facility-specific quantity and mix of medical care providers necessary to satisfy these peacetime requirements.

The PRISM provider estimates can determine expected demand for health care and the proper mix of health care providers to satisfy that demand. It also assists in the determination of quantity of providers and types of specialties to sponsor in graduate medical education or to recruit.

The model recognizes three factors. First, the military beneficiary population has health care requirements that differ from those of the general U.S. population. Second, the health care requirements of the military population change over time as the composition of that population changes and that the health care characteristics of the beneficiary populations, and hence their health care requirements, vary significantly across service areas.

SIZING

The facility sizing and requirements determination process is based on detailed analyses. The requirement for a medical facility is identified at the base level. The review process begins with a joint medical and civil engineering effort with assistance from special consultants from the regional health facilities office and by major command medical and civil engineer representatives.

Three major factors are considered—mission changes which include realignment actions and significant changes in the health care catchment area; technological improvements that require facility modifications to support new equipment and/or treatment modalities (e.g., computed tomography scanners, magnetic resonance im-

agery, linear accelerators, extra coporeal shock-wave lithotriptors) and facility obsolescence which includes fire/life safety code deficiencies, mechanical/electrical/utility systems deterioration, and structural/functional deficiencies.

The needs assessment process includes evaluation of JCAH standards, National Fire Protection Association (NFPA) codes, and adherence to DOD and Air Force construction directives.

Based on the needs assessment, the project is included in the major command's five-year program where it is prioritized with all other projects. The major command's prioritized five-year program is reviewed annually by my staff. The factors considered in our review are: readiness/contingency requirements; validation of needs assessment; annual availability of construction funding within the five year program; and level of CHAMPUS workload that can be recaptured into the direct care facility. The result of this process is an integrated priority list of all medical projects that are reviewed and approved annually by the DOD Health Facilities Planning Review Committee chaired by the Office of the Assistant Secretary of Defense (Health Affairs).

An economic analysis is developed in a seven-step process that results in a cost-effective recommendation for facility sizing. The initial step is to identify and document all the health care resources available in the area of the medical treatment facility (e.g., civilian hospitals and clinics, health maintenance organizations). In addition, an architectural and engineering assessment is made of the ability of the existing military facility to provide care. This assessment includes an examination of the military facility and site; documentation of existing military health care resources; and investigation of the potential for VA/DOD resource sharing.

Following this assessment of the total health care demand (direct care, CHAMPUS, and other) of the catchment area population, the facility's target occupancy date is forecasted, using utilization rates and population projections. At this stage, alternative scenarios for providing care to uniformed services beneficiaries are defined. The cost-effectiveness of each scenario is analyzed and the scenarios are subsequently refined according to the cost analysis results. For example, the minimum workload level for the facility is defined as well as the maximum workload that would be provided in the direct care facility if it were adequately sized and staffed.

Alternatives are considered, such as closing the military facility and providing all care through CHAMPUS, military referral facilities, and VA facilities, or providing a baseline facility adequate to provide care for active duty and their dependents plus 5% (nonteaching hospitals) or 10% (teaching hospitals) for retirees and their dependents. Staff requirements are then determined.

For each of the above scenarios, square footage requirements are calculated using DOD facility sizing criteria. DOD space planning criteria enable us to build sufficient square footage into patient rooms to meet validated wartime inpatient requirements. For an additional two percent construction costs, fifty percent more inpatients can be cared for in wartime. A construction alternative that will best utilize the existing facility and also satisfy the space requirements is then developed. Both addition/alteration and new construction options are considered. The construction cost for the recommended solution is then estimated.

The final step is to analyze the alternative scenarios for cost-effectiveness. This step involves comparing direct care operating and construction costs against non-direct care costs to determine the most economical approach for satisfying health care demand.

A project proposal is then developed based on the economic analysis. The project proposal includes the following: summary of facility deficiencies; mission of the facility; current and projected population; historical and projected staffing and workload; added/changed services or functions; health agency notification; proposed construction; room by room space requirements; installation master plan; and listing of area federal and nonfederal hospitals (including current utilization, distance, and size).

CONCLUSION

The Air Force Medical Service is providing quality cost-effective health care to our nearly three million beneficiaries worldwide. We have taken decisive steps to ensure that the quality of care is closely monitored. The inadequate and the incompetent provider is dealt with swiftly and firmly. Quality assurance will continue to be of paramount concern to me and to the Air Force leadership. Our programs and policies for staffing and sizing our health care facilities complements our quality assurance effort to provide the required number and best mix of health care providers in a modern, safe, well designed facility.

I will be happy to answer any questions.

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Senator WILSON. All right. Thank you.

Mr. Gilliat, do you wish to make any further statement relative to today's hearing, or just enter your statement for the record.

Mr. GILLIAT. I would enter my statement for the record.

Senator WILSON. All right.

Thank you.

With us today is Robert L. Gilliat, let me say, who is accompanying Dr. Mayer. He is here today, as I understand it, as a resource really to respond to legal questions.

Is that correct?

Mr. GILLIAT. Yes; it is.

Senator WILSON. Mr. Gilliat is the assistant general counsel for the Department of Defense and brings to that responsibility a long and distinguished legal career. We are pleased to have him with us today and to accept his statement for the record.

[The prepared statement of Mr. Gilliat follows:]

PREPARED STATEMENT OF ROBERT L. GILLIAT, ASSISTANT GENERAL COUNSEL (MANPOWER AND HEALTH AFFAIRS), DEPARTMENT OF DEFENSE

Mr. Chairman and Members of the Subcommittee: I appreciate the opportunity to present the views of the Department of Defense on proposals to modify the *Feres* doctrine. These bills, S. 489 and H.R. 3174, though differing in some respects, would allow members of the Armed Forces to sue the United States for damages for certain injuries caused by improper medical or dental care.

At the outset, it is important to address the real issues raised by these bills: how do we deal with what the General Counsel of the Department of Defense, Chapman B. Cox, has described as the "menace" of malpractice in the military health care system. We must assure that every effort is made to eliminate malpractice. This can be accomplished only by obtaining the best health care providers available, monitoring their work, and holding accountable those whose performance is substandard. The quality assurance initiatives that Dr. Mayer has described can accomplish those objectives; permitting military personnel to sue the Government for the errors of Defense physicians and dentists will not.

We share this subcommittee's compassion for those who have been injured through medical treatment in our facilities and would welcome an opportunity to assist in identifying and correcting any deficieincies in existing compensation that may be identified. The Department of Defense strongly suggests, however, that the suits that these bills would authorize will neither improve the quality of medical care in the military nor achieve the just and equitable result for which we all strive.

In 1946, after three decades of legislative effort, Congress passed the Federal Tort Claims Act.[1] The primary purpose of the Act was to relieve Congress of the enormous burden created by the thousands of private relief bills seeking money damages for injuries caused by the Federal Government and its employees. Prior to the passage of the Act, such bills were the only means by which an injured individual could be compensated, because sovereign immunity blocked civil actions.

The Federal Tort Claims Act waives sovereign immunity in broad language. It makes the Government liable for tort claims based on the negligent or wrongful act or omission of any Government employee while acting within the scope of his or her office or employment. This liability is determined "in the same manner and to the same extent as a private individual under like circumstances." [2] There are some specifically enumerated exceptions to the general grant of tort jurisdiction, such as discretionary governmental functions, assault and battery, and claims arising in foreign countries.[3] However, no provision in the Act expressly permits or prohibits the claims of members of the Armed Forces.

Shortly after passage of the Federal Tort Claims Act, courts were faced with the issue of the servicemember's right to sue under the Act. In 1949, the Supreme Court held in the case of *United States* v. *Brooks* [4] that the plain language of the Act did

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[1] 28 U.S.C. § § 1346(b), 2671 *et seq.* (1982).
[2] 28 U.S.C. § 2674 (1982).
[3] 28 U.S.C. § 2680 (1982).
[4] 337 U.S. 49 (1949).

not exclude claims by servicemembers. In *Brooks*, two brothers, both active-duty servicemen, suffered injuries in an automobile accident. They were on military leave and off base on a public highway when they were struck by a Government vehicle. The Supreme Court allowed suit under the Federal Tort Claims Act, but expressly limited its holding to claims that were not incident to the service of a military member. The Supreme Court reserved decision on the "wholly different case" of injuries that are incident to service.[5]

In *Feres* v. *United States*[6] the Supreme Court faced that "wholly different case." The *Feres* case involved a widow suing under the Federal Tort Claims Act for the wrongful death of her active-duty husband, who died in a fire while he slept in his military barracks. The Court unanimously held (Justice Douglas concurring in the results) that "the Government is not liable under the Federal Tort Claims Act for injuries to servicemen where the injuries arise out of or are in the course of activity incident to service."[7] In *Jefferson* v. *United States* and *United States* v. *Griggs*, which were companions to and decided at the same time as *Feres*, the Court held that the rendering of medical care by a military health care facility to an active-duty servicemember was incident to the service of that member.[8] The *Jefferson* plaintiff had an abdominal operation that apparently was negligently performed. In *Griggs*, the executrix contended that her decedent died because of negligent medical care by Army surgeons.

Each of these cases involved a patient who was an active-duty member of the Armed Forces allegedly injured by others in the Armed Forces. The Supreme Court held that the Federal Tort Claims Act did not waive sovereign immunity in these cases.[9]

The court focused in the *Feres*, *Jefferson*, and *Griggs* cases on the language in the Federal Tort Claims Act that makes the Government amenable to suit "in the same manner and to the same extent as a private individual under like circumstances. . . ." It concluded that the circumstances of the relationship between a servicemember and the Federal Government are not analogous to those of a private individual and that, accordingly, the Act did not create a cause of action for incident-to-service injuries. The Court reviewed, in the course of its opinion, several policy consideration that argue against giving the servicemember a right of action under the Federal Tort Claims Act, and it suggested that only an "express congressional command," which it did not find, would indicate that Congress intended to create such a right.

The major policy considerations that impressed the Court in *Feres* were:

(1) the effect of intramilitary suits on military discipline;

(2) the existence of a uniform and comprehensive system of statutory compensation and benefits available to servicemembers and their dependents or survivors; and

(3) the lack of uniformity of state laws.[10]

I would like to review these important policy considerations, which originally justified and continue to require the retention of the *Feres* doctrine and which are fully applicable to medical malpractice cases. However, the subject of *Feres* as it relates to medical malpractice has assumed such emotional proportions that any discussion requires the identification and analysis of facts which are frequently obscured.

First, interest in this subject has not been stimulated by an extraordinary rate of malpractice in military facilities. There is no respectable body of evidence establishing that military medicine is any more negligent than its civilian counterpart. Indeed, a recent study by the Office of the Assistant Secretary of Defense (Health Affairs) showed that, during 1983 and 1984, the rate of malpractice claims against military doctors brought by non-active duty patients for treatment received was about 6.4 per 100 physicians, in contrast to 16.5 per 100 physicians in civilian practice. An extrapolation that takes *Feres* into account by including claims that could be brought by active-duty members produces a rate of 8.7 per 100 physicians, roughtly one-half the rate of civilian practitioners.

Second, even though DOD malpractice rates are relatively low, the Secretary of Defense is determined to eradicate malpractice in the military medical system. To that end, the Department has vigorously established a wide range of procedures to promote and monitor quality assurance.

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[5] *Id.* at 52.
[6] 340 U.S. 135 (1950).
[7] *Id.* at 146.
[8] *Jefferson v. United States* and *United States v. Griggs*, 340 U.S. 135 (1950).
[9] *Feres*, 340 U.S. at 141.
[10] L. Jayson, *Handling Federal Tort Claims*, § 155.05 (1977).

Third, we are not opposed to increased benefits—indeed, we would favor them if they are shown to be necessary in light of changed economic conditions, but believe they should be provided within the existing compensation scheme. We fully support a system of benefits which provides adequate compensation for injured service personnel without damaging the fabric of military discipline that is essential to mission accomplishment.

Fourth, the concept of *Feres* is not unique. Its analogue prevails in workers' compensation statutes in virtually every state.[11] Similarly, within the Federal sector there are the Federal Employees' Compensation Act [12] and the Longshore and Harbor Workers' Compensation Act [13]—both of which provide for no-fault compensation of work-related injuries to the exclusion of tort remedies. These statutes exist for many of the same reasons that the Supreme Court originally enunciated in *Feres*, notably the need for a comprehensive, uniform, and predictable system of benefits. They reflect a broadly-based social and legal philosophy, whose objective is to protect the productivity and integrity of the workplace while adequately compensating injured workers.

Like their non-military counterparts, all active-duty military personnel injured incident to service are compensated, relatively quickly and in accordance with the same rules, apart from the divisive, expensive, time-consuming, and erratic process of litigation. Moreover, the bond between military superior and subordinate differs markedly from that of employer and employee, and it has long been recognized as far more special than commercial relationships born out of the marketplace. *Feres* is a judicial acknowledgment of this bond.

Inasmuch as the bills under consideration would partially set aside a doctrine that has served for 35 years, it is appropriate to return to the factors of the *Feres* rationale, questioning whether they are still valid. We think they are.

The first factor was the unique relationship of the soldier to his or her Government and unit. This relationship, as courts have traditionally recognized, is characterized by the requirements of discipline, order, and cohesiveness. In *Feres*, the extraordinary nature of the relationship led the Supreme Court to conclude that there was no analogous private liability upon which to predicate Federal Tort Claims Act relief. Elimination of *Feres* in favor of the litigative process would unquestionably erode this relationship. More simply stated, the bonding which is essential to an effective military organization cannot exist in an environment which allows and encourages its members to seek damages for the actions of their compatriots in the line of duty.

Significantly, either bill, if passed, would be the first statute to invite suit by a subordinate against the Government for the legitimate exercise of judgment by a superior. The door to the Federal courts would swing open to any servicemember upon the bare allegation of medical malpractice in a hospital. We foresee a proliferation of litigation, not only to remedy injuries caused by malpractice, but also to ventilate other grievances.

This concern is supported by experience with litigation following the Supreme Court's creation of a Federal cause of action for violations of constitutional rights. According to statistics recently provided by the Department of Justice, there have been at least 12,000 constitutional tort lawsuits. Some 2,600 of these are still pending and involve over 10,000 Federal employees. Against this mass of litigation are only 29 verdicts favoring plaintiffs. Some of these have been overturned on appeal, while others are still under appellate review.

Ironically, to protect the Armed Forces and Federal civilian workforce from this disruption, in 1982 the Supreme Court relied heavily upon the rationale of the *Feres* doctrine in erecting a similar jurisdictional bar in *Chappell* v. *Wallace*[14] and *Bush* v. *Lucas*.[15] Until these decisions, dissatisfied military members and Federal employees with increasing frequency used and abused the concept of constitutional tort to challenge their supervisors.

At first blush, widespread challenges to military decisionmaking would appear remote from entitling servicemenbers to sue for medical malpractice injuries. However, military health care practitioners often make determinations upon which commanders rely. The resulting decisions of the commanders frequently are contrary to the personal desires of the member and may have an adverse economic impact on the member. Under the bills before you, any such decision might become subject to

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[11] *See generally*, 2A A. Larson, *The Law of Workmen's Compensation*, § § 65–67 (1983).
[12] 5 U.S.C. § 8116 (1982).
[13] 33 U.S.C. § 905 (1982).
[14] *Chappell v. Wallace*, 462 U.S. 296 (1983).
[15] *Bush v. Lucas*, 462 U.S. 367 (1983).

attack in a tort action alleging that a negligent medical finding resulted in physical discomfort and emotional distress. Indeed, in some jurisdictions, an allegation of emotional distress alone would suffice.

Each decisionmaking process within the military provides an avenue of appeal or review while still preserving the essentials of discipline and chain of command. Permitting malpractice actions by active-duty members would create the specter of a collateral means to attack these time-tested grievance-handling procedures in any case involving a medical determination.

The implications of changing the *Feres* doctrine are far more extensive than a cursory examination would suggest and unfortunately go far beyond providing tort remedies for extraordinarily grievous injuries. Numerous administrative actions and command decisions are directly dependent upon medical determinations made in hospitals operated by components of the Department of defense.

Several hypothetical cases illustrate the potential for misplaced attacks upon military decisions through resort to Federal Tort Claims Act suits under the proposed bills. Consider the following:

a. A pilot physically disqualified from flying status sues, alleging that a negligent medical error caused emotional distress. If brought in a jurisdiction which permits an action for negligent infliction of emotional distress, this action could provide an otherwise unobtainable judicial forum to challenge a military personnel assignment decision through litigation.

b. An officer disqualified from nuclear weapons duty as a result of a medical examination sues for emotional distress on the theory of medical negligence. Should we subject the selection of personnel for highly sensitive duties to protracted and unpredictable tort litigation? This list is by no means exhanustive, but should serve to point out that the implications of permitting malpractice suits by active-duty members go far beyond furnishing a money-damage remedy for physical injuries. Although the attack on command decisions is particularly objectionable in these hypothetical cases, the potential for incursions into command prerogatives would exist if any intramilitary damages litigation is authorized under the Federal Tort Claims Act. All medical decisions in the United States and the actions which flow from the Act could become fair game in Federal Tort Claims Act actions under the existing bills. The administrative process would become a turmoil, and personnel determinations affecting a member's status could remain in limbo for lengthy periods until judicially resolved.

A second factor in the *Feres* rationale is the lack of uniformity in state laws or, more positively, the desirability of uniformity in dealing with all service-connected injuries. The Supreme Court noted the unfairness which would result if the remedy for these injuries were determined by the fortuitous location of the member's assignment. Inasmuch as the Federal Tort Claims Act provides a tort remedy based upon the law of the situs state, the Supreme Court recognized that identical injuries could have dramatically different results. While civilians choose to be where they are, active-duty military members are not free to select their locations.

Under the bills, remedies and results would depend upon location. A cause of action and recovery would be made subject to the vagaries of more than 50 different sets of local laws. Moreover, recovery would be denied to those injured overseas because of the "foreign country" exception of the Federal Tort Claims Act. Likewise, recovery would become dependent upon such incalculables as regional bias, philosophical disposition of the judge, ingenuity of counsel, and workload of the United States Attorney's office. Such a formula, in our view, neither provides fairness nor supports the positive values necessary for the preservation of military esprit de corps. Ironically, reliance upon the traditional tort system is increasingly questioned in states that are struggling with the well-publicized problems it has created.

The third factor in the *Feres* rationale is the existence of a comprehensive, no-fault compensation system of military and veterans' benefits. As already noted, virtually every state has statutorily affirmed its preference for this approach. Moreover, the Congress has previously agreed by passing the Federal Employees' Compensation Act and the Longshoremen's and Harbor Workers' Compensation Act, each of which provides for exclusive no-fault remedies for job-related injuries.

Other impacts, not specifically considered by the *Feres* Court but which cannot be ignored, are human and financial costs. Aside from judgments that are open-ended and frequently bear no logical relationship to the extent of physical injury, the potential indirect burdens are astronomical. Any increase in litigation will result in a commensurate increase in the legal staffs of all military branches and the Department of Justice. Additional medical personnel would also be necessary, not for patient care but to assist in defending such litigation. Moreover, the disruption to mili-

tary readiness caused by the attendance of servicemembers as witnesses and litigants at trials, many years after the event, could well impair mission performance.

We share fully your heartfelt concern for those injured through medical malpractice. As Dr. Mayer and the Surgeons General has demonstrated, the Department has taken strong steps to minimize medical injuries and to provide top-quality care. We are convinced that the solution to the medical malpractice problem is through aggressive quality assurance measures such as those that the Department has instituted in recent years.

In conclusion, broadening Federal Tort Claims Act coverage to permit litigation by servicemembers would not deter medical malpractice. Instead, such a step would foster divisiveness within military units by inviting soldiers to sue for damages based on the superiors' actions.

For these reasons, the Department of Defense opposes legislative modification of the *Feres* doctrine.

Senator WILSON. There is much that we can cover, so we may, I think, seem to leap around a bit from subject to subject.

We have heard much from all of you about the medical quality assurance programs which each of the services has instituted. That, of course, is central to our inquiry, or at least to a significant portion of what we are concerned about today.

I would like to be reassured, and several of the things I heard this morning are reassuring. But I am not quite clear how they fit into some of the anecdotal horror stories that we have been hearing. I would like to develop that further.

I am particularly interested in your relating as specifically as possible the departmentwide and Air Force audit reports, from which I quoted in my statements, to your quality assurance programs. But the setting in which this occurs, as you are all too well and painfully aware, includes the unhappy anecdotal experiences that relate, in the Army, General Becker, to the hiring of Abraham Asante as an anesthesiologist at Fort Dix.

Why was it that it was not determined earlier than it was that he was clearly unqualified to serve as an anesthesiologist? Was the fault the fact that regulations that were in place were violated?

General Chesney, you can be thinking about how and why it was possible for Dr. Watzinger at Keesler Air Force Base Hospital to render possibly hundreds of inappropriate pathological diagnoses before that problem was uncovered.

Admiral Seaton, you, I am sure, are sick to death hearing about Dr. Billig. But he was recruited and he was made the chief of cardiology at Bethesda.

You cannot only respond to each of those specific complaints, but I would ask you overall to respond to the DOD and General Chesney to the Air Force audit about health care quality.

General Becker, I will afford you the privilege of going first in the tradition of being the senior service.

General BECKER. There are some days it just doesn't pay to be in the senior service, I guess. [General laughter.]

Senator WILSON. That is an honor you would just as soon not have right now, I guess.

General BECKER. I am very pleased to talk about Abraham Asante.

As you know, he is now serving time in a Federal penitentiary.

He was recruited as a civilian anesthesiologist and went to Walson Army Hospital, which is up at Fort Dix.

He did not have to show his papers. I am not sure why. He went there in June of 1983.

I can tell you this: When it was discovered that he did not have a proper medical diploma, the hospital commander was relieved, and, of course, Mr. Asante was taken into custody and was tried and convicted in Federal court on several charges that related to his fraudulent employment.

Senator WILSON. Well, let's just take this as a case in point.

I think the most significant thing you said in response is that you don't know how or why it was that his credentials were not examined.

We are not interested in the anecdotal horror story, except insofar as it may reveal some systemwide deficiency.

The DOD audit found at 16 facilities that 712 of 883 providers were granted privileges by the gaining facility prior to receipt of the provider's credentials files from the previous facility.

Now that is 80 percent of the cases.

Would you tell me—and I am going to ask each of the Surgeons General this—why we have a credentialing program if previous credentials aren't even considered?

General BECKER. I think that it is a fact that people were granted privileges without looking at a credentials file.

Senator WILSON. Why is that?

General BECKER. I can't answer that, sir.

I can tell you what it is now: They don't grant any privileges without looking at their credentials file, and everything is verified on it.

Senator WILSON. Can you tell me, General Becker, was there a regulation requiring that examination of the prior credential at the time Asante was hired? You have told me that the hospital commander was canned. I think he should have been.

But was there a regulation in place that required him to do something and was he simply guilty of dereliction of duty?

General BECKER. That's correct. There were regulations in place. The Army regulations stated that he was supposed to present certified, true copies of his medical diploma and his medical training and evidence of State license.

He was a civilian, so he came to us a little differently than the way they are hired, than the military are hired.

Now, a military doctor can come from, let's say, a residency program in the military. I think what happened, at least back in the years when I was chief of orthopedics and on the credentials committee, if we knew the person, we did not always examine the file. That was part of what the audit agency found.

But it is much tighter now, In fact, it is very tight.

Senator WILSON. So, what you are saying is that professional courtesy kept people from actually making the examination, and they were simply taking it on faith, but that that no longer occurs?

General BECKER. Yes, sir; but I am not sure it is quite "professional courtesy." But one could look at it in that way, I think. It was by professional knowledge of practitioners.

Let me put it this way for the record: it was loose, and it is now tight.

Senator WILSON. Well, all right.

Gentlemen, I want to move on, not that I think we have exhausted that subject.

Credentialing is hardly our only problem.

General Chesney, what about Watzinger? How was it possible for this woman to render really these countless wrong diagnoses before being detected?

General CHESNEY. When Dr. Watzinger came into the Air Force, she was a board certified pathologist, having had 6 years of postgraduate training after medical school and various other things, had been licensed, had good recommendations from her program director, was felt to be a very adequate pathologist.

And I think she would be considered an adequate pathologist—if taken alone and looking at what she does as a pathologist separately.

However, she had an interpersonal relationship problem with the rest of her hospital peers and would not consult on cases.

Most pathologists have an error rate of somewhere between 1 and 4 percent in their diagnoses. No single pathologist is perfect. But those problem cases are always taken to someone else, and you argue them out and come up with what is normally a pretty good diagnosis.

Dr. Watzinger did not do this. She did not take problem cases to her peers. She did not send them out necessarily. This was the problem. She was making all the diagnoses under her own direction.

Senator WILSON. Let me interrupt you there.

If the statement that you just made, that the rate of error customarily for pathologists is one to four——

General CHESNEY. One to four percent.

Senator WILSON. Yes—1 to 4 percent—that may seem like a small percentage, but considering the magnitude of the error if they are wrong, it is much too high.

Now, the point that you just made I think is one that common sense would dictate, and that is that there not be such supreme professional arrogance that there be no consultation.

Again, given the critical nature of the decision, should there not be a protocol in effect that requires that there be this kind of consultation?

General CHESNEY. Yes, there should. And we have it in effect in the Air Force now. We did not then.

Senator WILSON. You did not at the time she was practicing?

General CHESNEY. We did not at the time.

There is no question but that we have had a failure of management and leadership in her case. They should not have let her do this, the local people. And those who were responsible have been disciplined.

Senator WILSON. So, what you are telling me is that there is presently a protocol in effect?

General CHESNEY. Yes, sir. There is a protocol in effect.

Senator WILSON. Is that true in the Army and in the Navy as well, General Becker and Admiral Seaton.

Admiral SEATON. I will take that one for the record, to answer it specifically.

Senator WILSON. Do you mean you want to reply later?

Admiral SEATON. Yes, sir.

[The information follows:]

We operate under the same tri-service instruction as the Army and Air Force. BUMED Instruction 6510.2E implements DOD Directive 5154.24. Our histopathology centers provide diagnostic and consultation services to our Navy hospitals. These centers are the authorized channels to forward pathology material to the Armed Forces Institute of Pathology for review.

We are working with the other services to develop a quality assurance program for pathologists and an Armed Forces medical examiner system.

Senator WILSON. General Becker?

General BECKER. For the Army, it is in effect that they will receive consultation on problem cases. It is not necessarily a policy that they have to have consultation on every case. The problem cases are up to their judgment.

Senator WILSON. My problem with that response is I gather that in the case of Dr. Watzinger, she felt that she had no problem, and that it was detected the hard way. She got a bad reputation the old fashioned way—she earned it, at the expense of her patients.

General CHESNEY. Sir, may I answer one thing.

All of the services now are working with the Department of Defense and the Armed Forces Institute of Pathology for a triservice regulation which will cover all of the services in this type of procedure. That is being worked out now and I think will be out very shortly.

Senator WILSON. Thank you.

Dr. Mayer, let me just ask this general question. As I said, we were likely to leap around, and I am guilty of doing so right now.

Considering the magnitude of the responsibility that you oversee, 10 million people and all of these facilities, all of these personnel, all of these patients, 56 million outpatient calls, focusing on the peacetime aspect of it, is there a need for a change in either the law or the regulations that now exist in order to permit the use of CHAMPUS for the purchase of services by what you have described as the more competitive civilian providers?

My impression from something that one of the witnesses this morning said indicated to me that some of them are making use now—I think General Becker indicated that they have two pilots working in Virginia for patients within the Washington area. Is there a need for change, or can it be done now?

Dr. MAYER. I think it can be done within the existing regulations, although, as I mentioned, we are doing pilot projects under a demonstration authority that the Congress gave to us.

If those projects appear to have a major contribution in the way we purchase care on the outside, and if we want to generalize those throughout the services, then we have to go beyond the demonstration authority and we would have to ask for specific authority to do that.

By and large, I think we are capable, at this point, with the regulations that we have, to make the effort to engage in contractual relationships. The personal services contracting has already been mentioned, and I believe that we don't need further regulatory change.

Is that true, Mr. Gilliat?

Mr. GILLIAT. I think the authority under section 1079 of title 10 is very broad for entering into a variety of relationships under the CHAMPUS authority. There are some minor problems in connection with the option of dependents to choose either care in the direct care system or under CHAMPUS that might require some slight revision of section 1080 if we wanted to require the use of the direct care facilities under some circumstances. But, basically, it is very broad, and we can do a great deal under the existing law.

Dr. MAYER. I should, if I may, Mr. Chairman, mention that we did have a legislative initiative last year which failed, establishing a link between CHAMPUS and Medicare. That would work this way.

If a patient under Medicare goes to a hospital, the hospital is reimbursed on the basis of diagnosis-related groups, a prospective payment system that the Department of Health and Human Services has put into effect.

That does not apply to CHAMPUS patients.

We would like the regulation or the law which requires that procedure for Medicare patients to be extended to CHAMPUS patients who are also Federal beneficiaries and paid for with taxpayers' money.

Unfortunately, when we have tried to get hospitals—and we did conduct an experiment in one State to see if this would work—we tried to get hospitals voluntarily to pay on the basis of DRG's for CHAMPUS patients, and the major hospitals in that State refused to do it. The belief is if the hospital feels that it is being caused to lose some money as a result of DRG reimbursement, they shift the cost to other kinds of payers, and that includes CHAMPUS.

CHAMPUS does not have any real leverage because it only constitutes about 1 percent or less of hospital admissions in civilian hospitals around the country, whereas Medicare represents about 40 percent.

So, nobody argues with the Medicare.

But we do need that kind of legislative change for what could be a major cost saving.

Senator WILSON. I want to pursue that further with you.

One of your final statements in your testimony, with which I have great agreement is:

> We believe the establishment of an effective military-civilian partnership in health can reduce costs and administrative burdens and increase satisfaction for beneficiaries and professional staff alike.

I think we very definitely need to pursue that.

You are right; when we attempted to do so last year, in the context of Medicare, objection was heard on the floor from the Finance Committee, which has primary jurisdiction in that area. But I think we need to pursue that.

Senator Glenn has graciously assented to defer his questioning to allow Senator Kennedy to precede him. Senator Kennedy has another appointment which will take him away, so we want to afford him the opportunity to ask questions now.

Senator KENNEDY. Thank you very much, Mr. Chairman, and I thank my friend and colleague, Senator Glenn, as well.

I want to point out the obvious, that many of the improvements which have been initiated in recent times have been as a direct result of Dr. Mayer's efforts, and these are not insignificant. I think a great deal of the energy and effort in the very recent time has been a result of these actions.

I think the actions obviously have ventilated a good deal of the problems. Now you are being asked about them, and appropriately so, in terms of trying to establish at least some judgment about whether we are doing enough in a number of these different areas which have been outlined in the defense-wide audit on the quality assurance programs, which I know you have addressed at other times. These audits show that 22 facilities granted privileges for 638 of 986 health providers to practice without sufficient evidence of providers' qualifications and current competence.

You respond that now you have the credentials requirements, you have at 11 facilities, 626 of the 2,600 prescriptions, laboratory results, or other information missing from patient medical records; at six facilities there were 241 medical records that could not be located.

It is awfully difficult to establish just a regulation and expect that those medical records are going to be in there. Perhaps the credentials, the easiest aspect in terms of trying to meet some of the obvious obligations—but this is a tough indictment in terms of what is happening in medical records. Then there were 14 facilities that did not perform timely reviews of emergency room records: 83 of 168 health care providers and technicians at four facilities did not have the necessary training for emergency care.

You have made the statement, Doctor, that you are at least equal if not better than the civilian sector. I just wonder what is the rationale, the justification, for that statement. If it is just opinion, you have the survey that has been made and brought into the record by the Senator from Ohio, the 1984 health care study of personnel that indicates active duty personnel and their dependents clearly felt the quality of civilian health care was superior.

I am interested in what steps are being taken.

We know that in the civilian area you have the Joint Committee on Hospital Accreditation that does the reviews; there are the studies in various hospitals, morbidity and mortality, there are continuing education programs that have requirements in terms of medical personnel. Why there is a whole range of different requirements.

Some hospitals comply with it and others do not. Some have lost their accreditation.

I am wondering if you can, very briefly, tell us what you are doing. First of all, what is the justification? I think, given your own record in terms of trying to give those assurances and your own willingness to talk about the warts on the system, that you have a good deal of credibility. So I would like to know just why you believe and how you can justify your statement today, given the fact of the extraordinary indictment of the whole system just a year or so ago?

Dr. MAYER. It's hard to know where to start because you have asked a number of questions.

Senator KENNEDY. Well, let me target it for you somewhat.

What are you doing now? You list in your statement some of the steps. But we know there is an elaborate set of procedures that go on for the hospitals for the assurances of quality. Do you exceed those basic requirements?

Dr. MAYER. Yes, sir; I think we do, and I will tell you why.

It is true that the Joint Commission sets up certain kinds of requirements for hospitals. Many of them are life safety issues. But, increasingly, they are focusing on quality assurance in the committees and in the minutes of the committees, that sort of thing.

First of all, with respect to Joint Commission accreditation, no military hospital has been denied accreditation by the Joint Commission.

Senator KENNEDY. How many have been inspected?

Dr. MAYER. All of the major hospitals; all but the very smallest.

Senator KENNEDY. How often?

Dr. MAYER. Well that is up to the Joint Commission. When they inspect you, they may accredit you for 3 years or give you a conditional accreditation for 2 or even for 1.

But, when you compare all military hospitals with all civilian hospitals who have been inspected by the Joint Commission, a higher percentage of our hospitals achieved a 3-year or 2-year accreditation, with very minor questions to be answered, than is true of the civilian hospitals; and no military hospital has been denied accreditation.

That is point No. 1.

Point No. 2 has to do with credentialing actions and the many other built-in quality assurance things that have existed for many years in medicine. For example, there are tissue review committees in most well-run, at least teaching, hospitals, though not necessarily in community hospitals. There are morbidity and mortality review committees. There are infection committees.

Those have existed in the past throughout American medicine to a varying degree in varying hospitals, and, generally, almost everything that can be thought of to assure quality, like those committees that review every death, review every hospital infection, and so on, in general, those have been limited largely to the very large, prominent—I'm talking about in the civilian communities—hospitals, teaching hospitals. And they have been pursued to a very spotty degree among smaller ones.

One of the things that gives the medical care system of the Armed Forces such a high level of quality is that what is required in the finest teaching centers—at the University of California in San Francisco, or at Peter Bent Brigham—is required now formally in all military hospitals, regardless of size and regardless of location. These things are not just imposed on them. We have ways, like the audit report that you quoted from, which allow us to find out immediately whether those rules are being followed or not.

Quality assurance, as a major, formalized process in American medicine, has only in the last few years gained any real force within the medical community.

In the past, we have counted upon the community of physicians to discipline themselves, to be conscientious about the processes that are necessary to make sure that things aren't getting out of hand.

We now find that in this era of accountability, with insurance companies wanting to know what they are paying for, and the Federal Government buying so much medical care and wanting to know what it is paying for, and patients with an increased level of understanding in this country, beyond any country on Earth, I think, of medical care and the miracles it can produce—and them demanding to know—we are now seeing, even in the civilian community, the formalizing of credentialing procedures, the formalizing of the reports of committees, which in the past have not been strictly adhered to.

I think we have the opportunity in the military, because of our structure, to put those things into place more quickly and more decisively; and I think we are leading the way.

That's why I think it is a very fine system.

Senator KENNEDY. We appreciate your response.

I see that the time is moving on. Let me ask you this question.

Can you give us some idea of comparison, for example, of the average length of hospital stay for military personnel now in a nonwartime situation and for civilians?

Dr. MAYER. Yes, sir.

The average length of stay in military hospitals is only a fraction of a day longer than it is in civilians. And it should be remembered that, in the case of a military person, like a sailor off his ship, if he breaks his leg while he is on shore leave in San Diego, we cannot put him back on the ship. He doesn't have a family to go to. He can't climb ladders on the ship as long as his leg is in a cast, for example, a full leg cast, and there are many other examples in the Air Force and the Army also where, if the individual——

Senator KENNEDY. Does that account for the differential?

Dr. MAYER. Yes.

Senator KENNEDY. You are satisfied that it accounts for the differential.

Dr. MAYER. Yes. It slightly increases our length of stay.

Senator KENNEDY. OK.

Let me go to the outpatient visit per person per year.

Dr. MAYER. The what?

Senator KENNEDY. Outpatient visits per person per year, those who need for that particular service—how do you compare with the civilian sector? Do you know?

Dr. MAYER. There is not a good basis for comparison, Senator Kennedy. That kind of statistic, which you would think would be very easily come by, is not a statistic that is kept on a national basis to give us valid comparisons.

I am not trying to evade the question. There really is not a standard against which to compare.

Senator KENNEDY. All right.

If I could, I would like to submit other questions on those particular comparisons, if I could, and get further responses.

Dr. MAYER. Surely.

Senator KENNEDY. The chairman of the committee talked about the experimentation that you are doing in your demonstration projects. I am grateful for the time that your people gave in terms of briefing my staff on these.

They appear to me, at the outset, to be very limited, with all respect. It appears to me that what is happening in Fort Ord is really a very limited program. I did not have a chance to get into it in much detail, but I think that the way that is structured, well, I am not sure, quite frankly, how you are going to get a lot of information that could be valuable to you generally in terms of the whole system.

You are contracting out in just one important area, and that is mental health, in the Tidewater Program, and the whole issue of the bone transplant is a very limited kind of need as well.

I would hope that we might be able to have a more expanded opportunity for experiencing and utilizing these other health delivery systems for military personnel.

I was interested in your response last week about your willingness to get into this. In reviewing the programs which have been developed, it appears to me that they are very limited. I would be glad to work with the chairman and with other members of the committee to see if we can't get some demonstration programs that really can be reflective of where and what opportunities are available to strengthen the quality of care and also to provide some additional relief to the military personnel.

We will not have a good deal of time to get into that right now. But I would hope that we would have a real opportunity and chance to do it because there are now a lot of innovations that are taking place in civilian health care.

Another area that I am very interested in is the increase in cost. Over the period 1981 to 1985, military costs have come up about 15 percent. If you take the number of personnel that you are treating, it is about 10 million. As I understand it, you have $10 billion, and that is very, very close to what we are spending in terms of civilian care—about $1,200 or $1,300 a person.

We have seen a much greater increase in terms of health care costs within the military than in the civilian, particularly in the last couple of years. Would you indicate what the reasons for that are? Or, if you would like to provide for the record a more detailed analysis, I would be glad to get it.

Dr. MAYER. I will do that.

But I would like to point this out also. A large increase in the amount of money that it is costing us to do business has to do with buying a half billion dollars worth of medical readiness equipment this year, for example, and budgeting for the procurement of deployable medical facilities. That is not to say that we are necessarily the cheapest health care service going, although when we have made comparisons between what it costs us to give care in the community, reimbursing under the CHAMPUS system with the cost of doing it in-house, so far it has shown very consistently that we do do it for less in our military hospitals than if the care is provided in a civilian hospital and we pay for it.

So the economists, as you know, just argue endlessly about it.

Senator KENNEDY. OK.

If you could provide for us in a more detailed way some analysis of it and its justification, I think it would be valuable. It would be very helpful.

Dr. MAYER. Certainly.

[The information follows:]

COMPARISON OF COST ESCALATION

From fiscal year 1982 to fiscal year 1986, the Consumer Price Index (CPI) for Health Care rose about 31%. During the same period, DOD's total cost of medical operations rose about 39%. However, about 14 of the 39 percentage points can be attributed to a change in the way DOD budgets for a accrued retirement costs for military personnel. Starting in fiscal year 1985, these costs of close to $1 billlion for medical care personnel were shown as part of military personnel costs. Previously, these costs were included in a separate appropriation. When the 39% increase is decreased by the 14% which can be attributed to the retired pay adjustment, the resulting 25% increase in the cost of DOD medical care from 1982 to 1986 compares very favorably with the 31% increase in the private sector.

Senator KENNEDY. Lastly, Mr. Chairman, I would hope that perhaps along the lines of what I think are very, very important hearings, we might have an opportunity to have a hearing on the *Feres* doctrine. I think it is enormously important.

I did not realize until I got here this morning that we were going to have the *Feres* testimony, today from the Assistant General Counsel.

I think this issue is a matter of enormous importance to military personnel. I take exception with the testimony that is being made by the Assistant Attorney General. Quite frankly, I think there is one issue that is raised in situations which are uniquely military, and I think there is another issue that is raised when they are non-uniquely military, such as in the physician-patient relationship.

The General Counsel points out the problems of privates suing generals. You may well have the problem of generals suing majors just as well.

This I think is a matter of great importance. It is also a matter of considerable complexity. I do think it is of enormous importance involving basic fairness to the military personnel. I would hope that we might have an opportunity to examine that issue at some other time in the course of the considerations of these hearings, because I do think it has an important impact on the whole question of quality, equity, and fairness.

Senator GLENN. Would the Senator yield?

Senator WILSON. Excuse me. Let me make one point.

Senator Kennedy, at the next hearing we have invited Senator Sasser to come and testify before us. He has expressed a desire to do so and we offered him his choice of days. Because of the nature of the next hearing, he has chosen to come then, which I think be appropriate.

I think it would be appropriate, Mr. Gilliat, if your schedule permits, for you to be in attendance then as well, because at that point we will be explicitly discussing the *Feres* doctrine.

The bill that Senator Sasser has introduced is before the Judiciary Committee. They have primary jurisdiction.

But we do have an interest in it since it does impinge on the quality of care.

Both you and the chairman of the Judiciary Committee are members of this subcommittee. Perhaps we can throughout inquiries, at least enlighten the investigation which Judiciary makes in that piece of legislation.

Senator Glenn?

Senator GLENN. That was basically the point I was going to make.

I am concerned that we involve ourselves in this—as to what impact it is going to have on the services—from a military standpoint. But I think that two-thirds or more of the consideration of this is going to be in judiciary, because it is basically a legal question, the rights of individuals as compared with their civilian counterparts and so on.

Senator KENNEDY. I am sure we can work closely together with the Judiciary Committee. Obviously they are going to be enormously interested in what the impact is going to be on the military forces, and I think that ventilating that particular issue in this committee will be very, very important in terms of their judgment.

Mr. Chairman, I want to thank you and Senator Glenn once again. I will have additional questions with regard to these particular issues that I would like to be able to submit, and I want to again thank you and thank the witnesses who are here today.

Senator WILSON. Thank you, Senator, for your attendance and also for your very clear and personally felt interest, and for your additional questions, which we will submit for the record.

Senator Glenn?

Senator GLENN. Thank you, Mr. Chairman.

The line of questioning that I wanted to start off with is much aligned with Senator Kennedy's line of questions.

Dr. Mayer, your statement that the overall quality of care in military medicine is equal to if not better than overall care in the civilian sector is one that got to me especially after I read the audit report. That audit report, and I will quote it—is a defensewide audit of medical quality assurance by the DOD Inspector General. I quote: "There was insufficient evidence of qualifications and current competence for 638 of 986 health care providers. That's 64.7 percent who were granted privileges at 22 medical treatment facilities—8 Army, 7 Navy, 7 Air Force."

That audit further pointed out, "A high standard for granting privileges was not maintained at medical treatment facilities." I read that to mean, that at the time of this audit, two out of three health care providers did not have adequate or proper credentials to practice.

Now, do I misread that? That is a horrible, hideous indictment of what is going on—if I am not misreading something into it.

Dr. MAYER. I think, sir, respectfully, you are misreading very seriously what that audit is saying.

Senator GLENN. Well, straighten me out.

Dr. MAYER. OK.

The audit did not say that those doctors were incompetent, nor did it say that they didn't have credentials.

What the audit was examining was whether the process for colecting and recording the results of those credentials reviews was actually being followed to the level of detail that we were beginning to require. It's not that those people were not qualified.

In fact, the audit does point out at other points that this was not a criticism of the quality of care—and it isn't a criticism of the quality of care. By way of comparison, and going back to my asser-

tion that the quality of care in military hospitals is equal to or superior to that in the civilian sector——

Senator GLENN. Yes; but the flip side of that is that we don't know that they are qualified. That is the important thing.

If I am coming in for treatment or my wife or family is going in for treatment at a facility, I want to know that the people there are fully qualified.

What you are saying is there are two-thirds of these folks that we don't know that they are not qualfied. That's true, But I want guarantees that they are qualified. That is the important thing. We don't know that according to this report.

Is that correct?

Dr. MAYER. It's about as correct as when you walk into the office of a professor at a major medical university, and that is to say that there isn't a record there either, other than his diploma on the wall, that really proves to you, except by the assumption that the faculty has approved of him and that he is qualified. But there is no proof for you that he is, in fact, qualified to do what you want.

That is the whole thing that is happening in medicine today, both in the civilian world and in the military. And I am saying that we are ahead. We are demanding in a more stringent way, in other words, that the documentation of the qualifications be pursued very strictly.

Now, when that audit was made a couple of years ago, when the actual study was done a couple of years ago, it is true that we did not have in place all the regulations and all the rules that we now have in place for making sure that the documents are being collected.

It's just as when they made a comment about the amount of recording that is done in the medical records in the emergency rooms. If they would let you do it and you would look at the emergency room records, in the overwhelming majority of hospitals in this country you will find that, when a patient comes in with multiple injuries, particularly, and there are two other patients in the emergency room, and some drunken person is also being brought in by the police, when they are administering lifesaving medical care, they don't stop at each stage and write down exactly what they did. Records have been very poor in emergency rooms.

Now we can correct that, as we can correct many things, by hiring another person, increasing our staff, putting him in the emergency room, just to stand there and write down everything that every doctor does.

Our records were poor and they are better now, even without hiring additional staff. But it was that kind of thing that we wanted the auditors to look at and that we sent the IG out looking for. We needed to dramatize to the people in the field that, even though we all are doing the things that are required for high quality medical practice, many of them are not recorded, many of them are not pursued as vigorously.

For example, a large part of the reexamination of credentials which the auditors found had not been done in a certain number of cases, in a majority of cases, was the fact that the credentials committees in those hospitals, which until that time were not governed by strict regulations but were meeting nonetheless and had been

for the last 10 years, that those committees were not meeting on schedule and catching up with people on the yearly or bi-yearly review of those credentials. It's not that they did not have credentials.

That is very important, because that audit has been very widely interpreted as attacking the quality of care, and it has not attacked the quality of care. It has attacked what used to exist, and which I say we have now corrected, our failure to document, our failure to meet on a timely basis.

Senator GLENN. You brought up the emergency room records, and I agree. I know that to stop in the middle of things like that to note down everything that is going to occur when you have multiple people coming in is not possible. But let me just read the rest of the thing that you referred to from that report.

I quote: "Fourteen facilities did not perform timely reviews of emergency room records." OK. But listen to this second part: "And 83 of 168 health care providers and technicians at four facilities did not have the necessary training for emergency care."

Dr. MAYER. I'm glad you brought that up.

There are various levels of emergency rooms.

In the first place, emergency medicine, as a specialty, is a relatively new arrival on the American scene, and there are very limited numbers of fully qualified emergency room specialists. There is even some dispute as to what constitutes an emergency room specialty qualified person. Is it a trauma surgeon or is it somebody who is very expert in infectious diseases, or both, or everything?

In a large hospital, it is frequently possible for us to have fully qualified people because we have departments of orthopedics and general surgery and thoracic surgery and internal medicine, who are either on call or present in the emergency room.

In the small hospital, that is not possible. That is why in recent years there has been an effort throughout the country to specify what level of emergency care an individual emergency room is. Obviously, one in a 50-bed hospital is going to have nothing there but a nurse.

The average military person who is on a military post, particularly away from a major metropolitan center quite naturally assumes that an emergency room is an emergency room, and that if you go there any time of the day or night, somebody totally qualified to take care of you in an emergency is going to be there.

Unfortunately, that is not altogether true.

We have convened a triservice group a year ago on the management of emergency rooms and how we should specify what kinds of training they have, what kinds of procedures should be outlined, and a large public education effort is then going to be necessary, once these recommendations are formalized, to inform our patients as to what level of emergency care is available. At the very least we will have emergency referral to a hospital if we have a small one on post that cannot possibly do real emergency trauma care. We will have a system for referring downtown so that it can be done.

Senator GLENN. Let me move for just a couple of minutes to a different subject.

I have been asked several questions by people and by doctors back home in Ohio during my last couple of trips back there about AIDS. I know that is not the subject here this morning, but I want to take the opportunity to spend just a couple of minutes on this.

I understand that you have instituted a screening test for AIDS virus for new recruits.

Dr. MAYER. Yes, sir. That is correct.

Senator GLENN. Can you tell us what the first results of that are?

Dr. MAYER. No, sir. It has not been test implemented yet.

Senator GLENN. It has not yet been implemented?

Dr. MAYER. No.

We do screening tests for all blood that is collected. We have about 50 military blood collection centers that we ourselves operate, and we do screen all donations of blood, first with a preliminary test called ELISA, which has some false positives. Any false positive test is then reevaluated with a much more expensive and extensive test called the Western Blot.

That is felt in the scientific community to confirm very definitely the presence of antibodies to AIDS. It does not detect the presence of the disease of AIDS, only that there are antibodies present in the blood showing that the individual has been exposed and has reacted.

Senator GLENN. The epidemiology board, I understand, has been studying the question and questioning whether they want to expand this to the whole military population. Has that been completed?

What do you think the recommendation is going to be there?

Dr. MAYER. The board has completed its deliberations and reviewed the literature and received testimony from consultants of all kinds, both from within and without the service.

They have written a recommendation to me which I have not yet seen. I believe that they will probably recommend—well, first, I do know first hand that they thoroughly endorse our screening of all new recruits, and denial of entry on to active duty of anybody who shows AIDS antibodies.

I think that they will probably recommend that anyone who is in imminent likelihood of deployment to an overseas area probably also should be screened.

Let me tell you briefly just why.

The first thing having to do with the recruits is that we vaccinate recruits that come into the service. If they have an impaired immune system, which AIDS causes, then their reaction to vaccination can be very dangerous and they can get a generalized illness.

Second, anybody that we are going to deploy overseas, particularly to areas of the world like the Middle East, North Africa, the Far East, is exposed to a number of disorders, including malaria, which is probably the commonest major disease on Earth, and it is necessary that they have an intact immune system if they are going to be exposed to such diseases, and even doubly is it important because if we immunize them against certain diseases against which we have immunity producing vaccines, then we risk, since some of those vaccines are live but attenuated or weakened viruses, making them ill with that.

Third, any soldier, sailor, airman, or marine who is overseas and who is in harm's way or potentially in harm's way is a walking bloodbank. We need him. We may need him to save the life of another soldier by a direct transfusion. We cannot risk exposing people who have not been exposed to this disease by direct blood transfusions.

So I think the epidemiological board, which, as you know, is made up of civilian scientists who advise the department——

Senator GLENN. Excuse me, but the obvious followup is if you find people who have AIDS now, will they be separated? What will be the policy to those on active duty now who show the presence of antibodies associated with AIDS? Will they be separated?

Dr. MAYER. That is a policy that is yet to be determined, Senator Glenn. That is something that all three of the services and my office will be examining jointly, after we all get the report of the epidemiological board.

Senator GLENN. What is you timetable on that, because this is not something that is going away? What is your timing?

Dr. MAYER. I expect that all the services and I will have had a chance to review the Board's findings within the next week to 10 days, and by mid-October we should be able to enunciate a policy serviceswide that will be very clear.

Senator GLENN. As to the testing of the whole population and also whether they will be separating people with AIDS or AIDS antibodies?

Dr. MAYER. Yes; although that is a harder one because it is not fully determined that the presence of AIDS antibodies necessarily means that you have or will get the disease.

Senator GLENN. You should have a policy statement on that by mid-October?

Dr. MAYER. We plan to. Yes, sir.

Senator GLENN. Thank you.

The potential of this whole AIDS thing has grown just so fast and is so mind boggling. I hope we are putting enough Federal resources into research on this thing. I know the President said something about a hundred-some million dollars the other day going into AIDS research, and then I heard some doctors question whether that was the actual amount going into it or not, into pure AIDS research.

If there is one thing we cannot afford to hold back on, I think it is research in that area. AIDS can be so devastating if we don't find out what goes on.

Let's talk about CHAMPUS versus in-house medical care.

Dr. MAYER. Yes, sir.

Senator GLENN. As I understand it, you are trying to bring a lot of that back in.

Admiral Seaton, I think you have a program to reduce some of the number of certificates of nonavailability issued for inpatient care under CHAMPUS, is that correct?

Are you planning to expand CHAMPUS, to curtail it, to convert it to other types of systems that would be more civilian oriented for those, say, in the Washington area, or Chicago, or Los Angeles, where we provide military facilities?

CHAMPUS provides what, about 25 percent?

Dr. MAYER. Yes, sir.

Senator GLENN. Twenty-five percent of the coverage.

What are you planning to do with CHAMPUS?

Admiral SEATON. Well, I think it was not just a specific Navy program. It was a Department of Defense wide program, and we did follow their direction because this was initiated a few years ago, when the CHAMPUS costs were spiralling.

So we did reduce CNA's, or certificates of nonavailability, and brought some of that CHAMPUS back into the direct care system which you have heard testimony today that consistent reviews indicate probably is less expensive.

Senator GLENN. Yes; I singled you out because your advance statement had a comment in it about that. Maybe Dr. Mayer should comment on that since it is a servicewide thing.

Dr. MAYER. Yes, sir. CHAMPUS is a DOD program, not an individual service one.

Senator GLENN. I mean the idea of bringing more of CHAMPUS back in.

Dr. MAYER. Well, some years ago, as Admiral Seaton just said, it was concluded that we ought to make every effort to bring as much CHAMPUS business as we could do back into the house, and all three services really turned to and recaptured, in a sense, a great deal of business that otherwise would have gone out on CHAMPUS.

This did not result in lowering the CHAMPUS budget, unfortunately, but it probably reduced the rate of escalation in the costs of that program.

There is a limit, however, as to how much of that business we can satisfactorily or reasonably try to bring back.

Senator WILSON. Dr. Mayer, in that connection, I know that this initiative is one which this committee some years ago pushed you to pursue. You have said today that there are studies that show that many of the procedures can be handled better and more cheaply in-house than through CHAMPUS.

Dr. MAYER. Yes, sir.

Senator WILSON. Would you share those with us?

Dr. MAYER. Well, I can't cite the exact studies now, sir.

Senator WILSON. Well, you needn't do so now.

Dr. MAYER. Then yes, we can.

Senator WILSON. We would like to have those for the record. There is some question as to whether or not that is actually the case.

[The information follows:]

MILITARY TREATMENT FACILITY COSTS

There have been many reviews of military treatment facility costs relative to costs in the civilian sector. A variety of methods have been used to determine military facility costs in the absence of a consensus on what costs are appropriate to allocate to peacetime medical care. The primary purpose of the military health services system is preparedness. What portion, if any, of the significant preparedness costs might validly be allocated in determining the costs of delivering peacetime benefits? There is no comparable dual role in the civilian sector to use as a model.

If preparedness costs are excluded and only the marginal costs of providing the peacetime benefit are used, costs per unit of care in military facilities would be small compared to those in the civilian sector. If all preparedness costs are added to

direct peacetime costs and the total is divided by the units of care provided, there would be no parallel in the civilian sector for a valid comparison.

In what we believe is a reasonable compromise, for this comparison, we have based military treatment facility costs on allocations derived from using the Uniform Chart of Accounts, which approximates the method used in civilian facilities.

The military treatment facility costs listed are the national averages. There is considerable variation from facility to facility, just as there is in the civilian sector, because of variations in the mix of types of patients and types of care provided. Civilian sector costs used for comparison also are national averages derived from CHAMPUS data for the same time period, fiscal year 1984.

Comparing costs by specific procedure is not yet possible. We are in the process of determining such costs in the direct care system, but confirmed data will not be available until approximately the end of 1986. In the interim, some comparisons by categories of care are provided.

There also is a significant difference in government costs under CHAMPUS for inpatient care, depending on the type of beneficiary involved. Dependents of active duty members paid the greater of $25 per admission or $7.10 per inpatient day, while the inpatient coinsurance for retirees and their dependents and for survivors was 25% of charges.

For example, the average government cost per inpatient day under CHAMPUS for dependents of active duty members was $596; compared to $304 in the direct care system, a savings of 49% in the direct care system.

Beneficiaries who pay 25% coinsurance also have other insurance coverage in greater numbers than dependents of active duty members, and the combination of patient liabilities and payments by other insurance reduced government costs under CHAMPUS to $347 per inpatient day, while the direct care system cost remained the same at $304, or a saving of 12% in the direct care system.

Combining the mix of types of beneficiaries using care under CHAMPUS, the average government cost per inpatient day was $448, with the cost in the direct care system representing a 32% savings.

Comparing costs per outpatient visit, the overall average under CHAMPUS was $52 compared to $39, or a savings of 25%, in the direct care system.

A comparison of the overall average costs by category of care is as follows:

Care category	Average cost per admission		Percentage difference
	Direct care	CHAMPUS	
Medical	$1,858	$2,115	14
Surgical	2,176	2,882	32
Maternity	1,232	2,031	65

Dr. MAYER. That is an assertion that has been questioned, partly because people say that on CHAMPUS you are paying part of the capital costs of a hospital that exists out in the community, whereas the services don't have such costs. So, naturally, it seems cheaper, but it really isn't, if you cranked in the cost of building in hospital in the first place.

There is no question but what CHAMPUS costs are higher, partly for the reason that we don't really have any control over them. We don't set a fee.

Once a patient has been approved to go out on CHAMPUS—well, first, as an outpatient, we have no control over that at all.

As an inpatient, even if we have given him a certificate of nonavailability so that he can go get his care downtown, he can select a hospital whose usual charges are very, very high, and we have no way to control that.

That is why we want to be included in the DRG process with Medicare patients. But that is going to require legislation.

General CHESNEY. If I may give a example, take bone marrow transplantation. The average cost on the outside is $125,000. We

think we can do it in-house for about $45,000. That is why we are doing that study.

Senator WILSON. Well, the thing we want to do and the reason we are interested in laying hands on the studies is that I have a feeling that we are counting beans by different systems here. I think we need to determine whether or not the accounting is in consistent terms all the way through. Otherwise, we are faced with a welter of conflicting assertions.

We want to make sure that we are talking apples and apples here.

Go ahead, Senator Glenn.

Senator GLENN. Dr. Mayer, you gave a speech on September 16, and you made a statement that for too long we have been asked to do too much with too little and there are alternatives. The time is now to reexamine the notion that maximum recapture of the CHAMPUS workload is best for our beneficiaries or best for our primary wartime readiness mission.

I suggest to you that some of the very substantial nonactive duty workload that you have traditionally been pushed to recapture may no longer belong in-house. Is this a reversal of policy, now, where you want to put more out on CHAMPUS or more to HMO?

I am getting conflicting signals here.

Dr. MAYER. No, sir. That is understandable.

Senator GLENN. It's only because they are conflicting. That's the reason I get that impression.

[General laughter.]

Dr. MAYER. Well, that's part of the reason.

What we are saying is that the kind of workload that we care for in-house isn't always relevant to the readiness mission, and some of the workload that is done on CHAMPUS could be relevant to the readiness mission, that is, some of the surgical work that is done outside, and so on.

If we can redistribute some of the patients that have been going out into our own house and some of the work that we have been doing in-house out, and not just increasing the workload on the military facilities—that's what I said we needed to call a halt to, that there's as to how much we can pull back of the CHAMPUS workload—but, whatever, we pull back of the CHAMPUS workload should have the best possible value with respect to keeping our doctors prepared in those special activities and those specialties that are needed in wartime.

Senator GLEEN. Well, that's OK. But that's pretty hard diagnosis to make, when somebody walks in with an illness or something, or you have somebody who says——

Dr. MAYER. Well, sir, no, that is not that hard to make. In an emergency we'd take care of anybody; and if it is a case that is likely to lead to surgery of the kind that we need to keep our plastic surgeons and bone surgeons and chest surgeons busy, then we are going to keep him.

Senator GLENN. You have some experimental programs, I believe, on working with HMO's and seeing what we can do there. Could you briefly—and I know our time is running out—run through some of that?

For an area like Washington, DC, or Los Angeles or Chicago, we have a civilian medical establishment at those places, and you have HMO's at all of those places, and if we just contracted for this, and put it out on competitive bid and had that cover so many military people or dependents and so on, maybe that would be a cheaper and better way to go.

Dr. MAYER. That's an easy assumption that a lot of people have made. But it's wrong.

Senator GLENN. Well, then, that's not the way to go.

But there are always going to be places like east-wherever-it-is, where we have a military base that does not have an HMO and does not have adequate civilian facilities to begin with, and so you are obviously going to take care of the dependents at those places and should. You are going to cause an awful morale problem with everybody.

I don't know that we need to go all one way or all the other. It seems to me you can tailor it where there are adequate civilian facilities, such as here, Baltimore, or New York. Maybe we can have one system there and at the remote bases have another. Are we set up to be that flexible about it? What are we doing in that area?

Dr. MAYER. We are set up to be that flexible about it, but the inherent resistance to change that exists in any big institution make for a kind of slow process. But I think we are going to be able to experiment very much more widely than Senator Kennedy indicated. These little projects are not really that little, and they must be tested.

For example, the HMO tests that we have done in three communities showed, No. 1, that the patients loved it. They felt that they had greater access and they just enjoyed care in the HMO. It did not save us any money.

This is partly because in signing people up for an HMO, you pay for everybody, and a lot of them didn't use any health care services and wouldn't have whether they were coming to us or going to the HMO.

So, it ended up costing us about the same as CHAMPUS was costing us. At least that is the preliminary finding.

Senator GLENN. It is. It was as expensive as CHAMPUS. I thought you probably would save some money there.

Dr. MAYER. Well, we did, too. But it turned out that we were paying for so many healthy people. You have to pay for everybody that you enroll.

Senator GLENN. You are dealing with a rather prime group there in the military. You are dealing with an age group that does not have some of the problems that HMO's have to deal with, part of the time, at least.

Dr. MAYER. Well, you are talking about the problem of adverse selection in some civilian HMO's. But it has to be remembered that we have a very large share of very small children. We have a large share of people who are retired.

Senator GLENN. You are paying for a big bunch of people, you said, who would not necessarily use this but it would cost more.

Dr. MAYER. Yes. We did have a healthier population.

Senator GLENN. Wouldn't an experience factor then show that the HMO's could bid competitively because there is not that much use of it?

Dr. MAYER. That's what we think. We think we can get HMO's to bid more competitively. We think we can talk to some of the hospital management groups or individual hospitals. We think this is a buyer's market for medicine right now and that we ought to be able to strike better arrangements.

You are absolutely right. It is going to have to vary. It is going to be different in Connecticut than it is in Texas, than it is in San Francisco.

But we can, I believe, take advantage of what is out there now at prices that will save both the beneficiary and the Government some money and give good care.

Senator GLENN. Thank you.

I want to submit some additional questions. I would appreciate your review of the questions and your answers so that we can include those in the record if we submit them to you.

Dr. MAYER. I would be pleased to do so.

Senator WILSON. Thank you, Senator Glenn.

Senator Bingaman, though not a member of this subcommittee, is a member of the full committee, and we welcome him here this morning. We are grateful for his interest.

Senator, if you have questions, we would be pleased to have you put them now.

Senator BINGAMAN. Thank you very much.

I want to thank you, Mr. Chairman, and thank the ranking minority member for allowing me to participate.

Dr. Mayer, let me just ask you this. I know that in your recent statements and in Secretary Weinberger's recent statements, there has been an emphasis on the need to use community facilities more, civilian facilities more. I guess my question is whether you think you have adequate authority the way things are presently written, the way the laws and regulations presently read, to go ahead and do the experimenting with different contracting arrangements, to make maximum use of civilian facilities at the present time—or do you need something else done?

I understand that there was a proposal earlier this year that would have given the Secretary of Defense the right to designate specific facilities, either military or civilian facilities, which had to be used if people wanted to obtain medical care through the system.

I don't know if that has gone anywhere, but I would be interested in your idea as to whether some additional authority is needed.

Dr. MAYER. At the present, we have demonstration authority, provided by Congress, with a limited amount of money, but enough to do at least the early studies necessary to decide whether we want to make major changes in the whole system for utilizing and interacting with the civilian community.

If those studies prove fruitful, then we quite probably will need additional authority if we are going to make major changes in the way we utilize civilian health care.

I would like to emphasize that I am not contemplating nor is any of us contemplating any major shift of the total percentage of our

patients that will get care on the outside. But we do think there could be a different mix of such patients going for health care outside, and we do think there are better ways to pay for it.

Senator BINGAMAN. Thank you.

Let me ask about the blue ribbon panel on hospital sizing. It came out with criteria or general guidelines for when hospital facilities need to be expanded.

I had real problems this year in the proposed budget coming from the administration understanding how we could justify going forward with a 20-bed hospital at Annapolis, in light of the position that the blue ribbon panel had taken and in light of their problems with building additional hospital beds when there were other facilities readily available.

I would be interested in Admiral Seaton's response as to why this was a unique situation, or Dr. Mayer's, either one.

Admiral SEATON. Who wants to go first?

Dr. MAYER. You go first.

Senator BINGAMAN. You don't need to rush to answer that question. Whichever prefers. [General laughter.]

Admiral SEATON. Well, as you know, by the time a facility is into the budget, the studies and the justification for its replacement probably started a number of years ago. You quote the blue ribbon panel on sizing, and certainly one of their most important recommendations was a compression of the time from when a local commander says gee, this facility is no longer adequate to supply the care necessary to carry out the mission, therefore we will start down that long and tortuous trail to replace it. The studies of justification for that hospital were indeed performed a number of years ago, and it is now "into the budget."

Senator BINGAMAN. But we have not passed on anything in the appropriations area for it as yet. So there is still time to turn back.

Admiral SEATON. I am fully aware of that. Yes, sir.

Senator BINGAMAN. Are you suggesting that, in light of the blue ribbon panel's conclusions and all, that it is really not a wise decision to go forward with the Annapolis facility?

Admiral SEATON. Sir, I would not presume in that fashion. I would say that I suspect that with your due deliberations, given the new findings of the blue ribbon panel, which were not available when the original justification was submitted, that you will make the right decision.

Senator BINGAMAN. Why would you suspect that? [General laughter.]

We seldom make the right decision. I don't know why you think we would in this case.

Senator GLENN. That's a little like some of my constituents are for it and some of my constituents are against it, and I'm for my constituents.

Admiral SEATON. Yes, sir. Very well put. [General laughter.]

Senator BINGAMAN. But we cannot, I gather from what you are saying or not saying, expect any kind of updated recommendations from the Department of Defense or the Navy as to the appropriateness of that facility.

Admiral SEATON. As of this day, it has progressed past that point. I guess the only thing I would say to you that may be helpful

would be in the light of the blue ribbon panel's recommendations and the changes in the whole American scene of health care, namely the increase of civilian capability, I am not certain today that the same justification would have been submitted.

Senator BINGAMAN. OK.

Thank you very much.

Let me ask about the Brooke Army Medical Center.

I visited down there earlier this year, and toured both that facility and the Wilford Hall facility. Quite frankly, it is difficult to explain to the average person on the street why whole floors at Wilford Hall are not being used while there is a need for additional facilities at Brooke.

Now I know one is Air Force and one is Army. But that would not be a satisfactory explanation.

I wonder, there again, if the blue ribbon panel's findings have in any way impacted on the decisionmaking. What are the plans with regard to the expansion of the Brooke facility, or better utilization of the Wilford Hall facility?

Dr. Mayer, maybe you could bring me up to date on this.

Dr. MAYER. Yes, sir.

The blue ribbon panel examined the issue of Brooke and what additional space was available at Wilford Hall, and decided to pass the buck back to me to decide what to do with Brooke.

Senator BINGAMAN. What did you decide?

Dr. MAYER. I have not yet decided, sir.

However, there are questions, particularly if we apply the rules and the criteria that the blue ribbon panel suggested we apply. I tried to apply very much the same kind of reasoning in my initial approval of a replacement hospital at Brooke, somewhat smaller actually than the Army wanted. But they acquiesced to that and we were proceeding with it.

Even that was felt by a number of members of the blue ribbon panel who communicated with me informally to be too big, and they did not think that, in light of today's realities of medical delivery systems and facilities that that hospital ought to be replaced, even at the size I had approved, which was 450 beds.

So we are restudying it, applying the criteria that the blue ribbon panel recommended that we use, and I have been strongly advised that if I go ahead and approve the hospital, at the size the Army has requested, that I will engender the outrage of all decent citizens, including 8 of the 10 members of the blue ribbon panel; but that if I attempt to reduce the size, that I will engender the hostility if not violent retaliatory impulses of a number of very important people in Government, and certainly of the Army. [General laughter.]

So, that is why I haven't decided yet. [General laughter.]

Senator BINGAMAN. I understand the Army has already let a contract for the design of a facility of 450 beds.

Dr. MAYER. Yes, sir; that is correct.

Senator BINGAMAN. So the cost of that design is pretty much nailed down.

When would you expect we would have a decision? I understand this is not a noncontroversial subject.

Dr. MAYER. I expect to have a decision by March or April.

Senator BINGAMAN. All right.

Let me ask about one other facility, if I could: Malmstrom Air Base Hospital.

I understand there is some controversy about whether or not it is really justified to go forward there.

General Chesney, you have indicated that you see some major savings by going ahead and building a 30-bed hospital at Malmstrom Air Base. I had difficulty understanding how that saving figure was arrived at by you. I have been advised that there are civilian medical facilities nearby which could accommodate the inpatient load that is contemplated for this new Air Force base hospital.

General CHESNEY. We have let a standard economic analysis, which is a commercial contract now, that we are doing now in all of our new hospitals to see if they are cost effective. That economic analysis report came back from the company that did that and said we would save $10 million over the lifetime of the facility by building the hospital and providing care inside.

There would also be a great amount of saving to our military personnel who have to pay the CHAMPUS cost-sharing if they go outside, over that $10 million.

One of the reasons that we want Malmstrom primarily has to do with the Personnel Reliability Program. That is one of our largest missile bases. We really like to keep in-house the people who have their finger on the nuclear button.

Senator BINGAMAN. I may have misread things here, but I thought your testimony, General, said it would save $8 million a year to have this facility, instead of $10 million over the life of the facility.

General CHESNEY. I will have to take that for the record. The figure that I got was $10 million—military.

I will take that for the record.

[The information follows:]

PEACETIME MEDICAL ISSUES

The $10 million savings (expressed as the 25 year net present value) I reference relates to a comparison of the cost of operating a hospital for only active duty personnel and their dependents to the cost of operating a hospital that also provides health care to retirees and their dependents. This economic analysis was accomplished in accordance with P.L. 97-337 and performed by a nationally recognized consulting firm.

When directed to construct a clinic at Malmstrom AFB, we estimated that the difference between operating a clinic and hospital will increase the health care costs to the government by $5.5 million a year (this equals a 25 year net present value of $50 million). Further, we estimate that our beneficiaries will experience a $2.5 million annual increase in their "out of pocket" costs for health care.

Please recognize that these are distinctly different estimates, each of which support that there is an economic advantage to the government to operate a hospital rather than a clinic at Malmstrom AFB.

General CHESNEY. Let me answer one other question about Wilford Hall, if I may.

When Wilford Hall was built, it was built for better patient care and really not for personnel economy. We had the people programmed in our budget to expand Wilford Hall to give that better patient care. But personnel caps prevented us from getting those people.

We are adding 240 to 250 more people this year. Wilford Hall today is 68 percent occupied, which is much higher than the civilian average right now of 64 percent across the United States this year. And the workload is there. We are turning patients away.

Senator BINGAMAN. Dr. Mayer, would you have any comment on the need for this Malmstrom facility?

Dr. MAYER. Yes, sir.

But first, let me say that I am totally sympathetic to the need to have very close control over the people in the personnel reliability program, particularly if they are going under anesthesia or things of that sort. But that is not an insurmountable problem.

The reason that I disapproved the construction of the 30-bed hospital at Malmstrom is that within I think about 2.5 miles of the gate of that facility there is a very excellent hospital, Deaconness Hospital, in Great Falls, which is a fully equipped tertiary care hospital.

It may be that in doing an economy analysis that shows the cost of CHAMPUS as we are presently doing it, that over the life expectancy of the hospital, which is something like 20 years, the economists can show that they are going to save x number of dollars. But they are comparing it to CHAMPUS costs, which don't take into account the fact that we are not going to go on doing CHAMPUS in the same open-ended way. We can't afford to do it. We are going to start contracting with hospitals.

There is one other point that has to be cranked into this equation. None of these issues is simple, as I know you are aware. There are many factors to be considered.

One of the problems is that military hospitals, by and large, were designed to do inpatient care. We do vastly more outpatient business, and we do more outpatient business than the average civilian hospital because in civilian hospitals, the outpatients go to the doctors' offices. We are all contained in one place.

This means that in many of our facilities, including Malmstrom, we are totally ill-designed to do the work that we have to do. So doctors don't have alternate examination rooms. They have to get out of the room to let the patient change clothes, and then come back in the room and write notes in the only room they have. This is terribly unproductive.

What I would like to see at Malmstrom is the development—and I approved this—the development of a really comprehensive, modern, well-designed, complete comprehensive health care facility with a few holding beds for patients that you need to make a decision about but that you don't need to make a decision about in a $600-a-day bed. But you would want them on site.

Then I would like to see the medical commander at Malmstrom given the authority to negotiate with the two very excellent hospitals in town to achieve the most beneficial arrangement for that hospital care that is needed for the majority of the kinds of patients they see there.

Now, you see, Malmstrom has only been running an average daily census of 12 patients. They cannot justify, in today's economic and military climate, expending the amount of money it would cost to build a 30-bed hospital to do that, even if they believe that they can restaff the hospital and bring more patients in.

I don't think that is economically sound reasoning.

So I want to give them a much better health care center than they have there now. The building is a disaster. It has cracks in the walls, it is falling down, it is a disgrace that we have to treat patients in that facility at all.

But if we are going to build a hospital there, it is going to take 6 or 8 years to complete that hospital, and we can complete a comprehensive, modern health care center at much lower cost—well, not that much lower, but it is significantly lower, though it is not just a fraction of the cost; it is more than half—but a really fine health care center. We can give the authority to the hospital commander to make arrangements with the hospitals downtown for the care of those patients who can be sent down there on a contract basis, where we can specify what kind of quality assurance we want to built into the contract, and specify what kind of preadmission reviews and things of that sort that we would like done. Then, if the need arises, certainly the core that we would have built at Malmstrom could serve to expand it into a hospital if that day should ever come.

But it certainly is not necessary, in my judgment at this point.

Senator BINGAMAN. Thank you.

Dr. Jarrett Clinton also headed another task force or blue ribbon panel that tried to look at health promotion and what could be done or should be done.

I would be interested, Dr. Mayer, in when you expect the directive to come out on that. I understand the directive is forthcoming. There is also a somewhat controversial issue as to whether you expect the issue of pricing tobacco products on military facilities to be part of that directive.

Dr. MAYER. Well, it is in the version that I signed and sent forward to the Secretary, sir. I don't think that we can run the details of everyday life, minute to minute, for every member of the Armed Forces, nor would I ever want to. But we have a full-fledged directive which has been very thoroughly participated in by all three services on health promotion, and a major part of the directive as we have proposed it essentially takes the position that no, we should not subsidize cigarette sales in the commissaries. We were told that is not really the business of the health people because the commissaries are not a health enterprise. They are in some other part of the bureaucracy.

Nonetheless, I think we had to make that statement.

Similarly—and this will end my career—I don't think we ought to subsidize booze at low prices on military posts either. I think it ought to cost exactly what it costs anyplace else.

We are not in a prohibition mode, now. But, especially for younger soliders if cigarettes are very cheap and booze is very cheap, the likelihood of them getting involved and using it is greater than if it were at the same price it would be downtown.

Senator BINGAMAN. Are you saying that those two items are handled in your directive.

Dr. MAYER. Well, now. The tobacco one is.

Senator BINGAMAN. The tobacco one is. So, once the directive is in place, then tobacco products will be priced at prices comparable

to the civilian sector on military facilities. Is that what you are saying?

Dr. MAYER. That is what we are advocating.

Now, that has not been approved all the way up through the Department of Defense.

We do, however, have in that directive, I think without fear of being shot down, a restriction on sales of tobacco products in hospitals. Those are our business. And also there are very serious restrictions on where in any hospital you can smoke.

We are not out to change the world. But we sure as heck are not going to foster the development of habits and behavior which we know contributes to our medical workload.

Senator BINGAMAN. Thank you very much, Mr. Chairman.

I appreciate the time.

Dr. MAYER. Thank you, Senator Bingaman.

Senator WILSON. Thank you, Senator.

We appreciate your interest.

Senator Glenn, did you have any further questions?

Senator GLENN. Thank you, yes, just one question.

I brought up the subject of AIDS before. You are in an excellent position, having had a lot of public health service as well as all the medical expertise around you there, are we spending enough on AIDS research right now? If not, what would you recommend be spent? Do you have an opinion on that?

Dr. MAYER. I cannot really make a judgment about that, Senator Glenn, because I am not privy to exactly how much is being spent. But I would say this, and it is a word of caution about simply throwing big pots of money even at a medical research issue.

The study of AIDS as a disease and as a phenomenon requires some of the most elaborate and sophisticated kind of immunological research and even oncological research in cancer kinds of things imaginable.

I believe, from what I have been told by the people in the Department of Health and Human Services and from the National Institutes of Health that we are making the most massive investment in research on this really terrible problem of any disease in recent years. Whether it is enough, or not, I think largely lies in the eyes of the beholder. There are always researchers who say I've got a great idea and we at least ought to try it out. There are others that say no, slow down, just pumping money at it is not going to solve it.

I am content that we are doing a massive and very workmanlike research job, both on the epidemiological research as well as on the basic science research necessary to come to grips with this problem.

It's just like cancer; no matter how much money we pump at it—and we have done this for years—we are still far from solving the majority of cancer problems.

Senator GLENN. We are, but this is a little bit different.

Dr. MAYER. But it has some great similarities. It's just that it's a more acute problem. That is true.

Senator GLENN. Do any of the rest of you have an opinion on that, on money being spent?

General BECKER. Sir, we have wrestled with the problem of where to do the research and we feel that the military position is

they do the clincial research and not get into the basic part of it, leaving that to NIH. Certainly it is a Federal problem. There is no doubt about that. Just where in the Federal Government to do it, well, at Walter Reed and our institutions are doing what we call clinical research, that is, studying the epidemiology and the patients with the disease.

Senator GLENN. Do you have enough money to do that?

General BECKER. Sir, we have asked for a supplemental for 1986, and I believe that is being considered.

Senator GLENN. How much?

General BECKER. Right now, we are at a place where it is going to be for the care of the patients testing and the clinical reesearch about $52.6 million.

Senator GLENN. I will support you.

General BECKER. Thank you.

Senator GLENN. Thank you, Mr. Chairman.

Senator WILSON. Thank you, Senator Glenn.

In line with Senator Glenn's last point and this whole line of questioning, you have responded that it is a little early for you, in your experience, to give us numbers with regard to the screening to determine the present of the AIDS antibodies. But, as I understand it, you have diagnosed some cases.

Could you tell us, each of the Surgeons General, how many cases you have diagnosed and what dispositon you are making of them.

[The information follows:]

ARMY

We have diagnosed 50 active duty Army cases and 26 other military beneficiaries as having AIDS or AIDS related complexes as of this date.

NAVY

Navy has thirty-four total active duty members with cases of AIDS; 30 Navy and 4 Marine Corps. Thirteen of these victims are dead. The remainder are either in the process of being medically boarded or have been boarded. All cases referred to the Central Physical Evaluation Board have been found with 100 percent disability and placed on the temporary disability retired list (TDRL). None have been on the TDRL long enough to have the first required reevaluation at 18 months.

AIR FORCE

The current policy of the Air Force, pending DOD recommendations has been to treat HTLV-III infection (HTLV-III anitbody positive) in a similar fashion as other medical conditions. Active duty members with AIDS are referred to Wilford Hall USAF Medical Center, and of the 14 identified, none remain on active duty. Individuals with HTLV-III infection with evidence of clinical illness which calls into question their fitness for duty are evaluated by a medical evaluation board, and referred to a physical evaluation board if necessary. Of the 16 members with this condition identified, 10 have been placed on the temporary disability retired list, 2 were returned to duty, 1 was administratively separated and 3 are being evaluated currently. The latest available data finds we have identified 3 individuals through the blood donor program, on active duty with HTLV-III infection with no evidence of disease. These individuals have been counseled, and are being medically evaluated.

Individuals entering onto active duty have been screened for HTLV-III since 1 October 1985. Thus far, of 2,473 individuals screened, 14 (0.6%) have had intitial and repeat positive ELISA screening tests. Of the 10 with Western Blot results available (the confirmatory test), 2 (0.08%) were confirmed as positive. These two individuals are being separated for this "existed prior to service" condition.

We are aware of 6 dependents and retirees with AIDS or ARC (AIDS Related Complex). These individuals receive normal medical care appropriate for their condition. There is no current central reporting requirement (other than to the Centers

for Disease Control) for this group of patients, and other cases may exist of which we are unaware.

General BECKER. Our experience so far, in screening the blood donors—the screening for all of the recruits starts on October 1. We had to get contracts to get the screening done, and people have been crashing to get that done. It is on track. On October 1 we will start screening everyone.

If I remember correctly, somewhere around 10,000 have been screened, and we have found approximately 4 per thousand of those people.

Now those are the ones that we picked up with the screen. We have diagnosed other people—wives of some people who have had AIDS.

Senator GLENN. Will screening keep them out, then? If they have AIDS, you will not accept them in the service?

General BECKER. That is correct.

When we start on October 1, if they are found to have AIDS, they will not come into the service.

Senator WILSON. And the ones that you have diagnosed?

General BECKER. We don't know whether they contracted that on duty, you know, as part of their service, if it is service connected, and we are treating them at the present time.

Senator GLENN. Will they be separated from service?

Senator WILSON. That I think is the more pertinent question, rather than how they contracted it. I understand legal consequences ensue, but the real question is: What do you do about the diagnosed cases?

General BECKER. We are treating them. We will medically retire some of those who have very serious, you know, who are in the end stages of AIDS, or transfer them to the Veterans' Administration. The decision has not been made, and that is the $64,000 question, as to whether we separate all of them or not, once we find they have AIDS.

It is a legal question, not a medical one.

Senator WILSON. Well, leaving alone the legal question, I guess what we are interested in here really is the health question.

General BECKER. You are talking about whether it is communicable or not. Our experts are wrestling with this on a daily basis. It is a fast-moving train.

We have staged AIDS, and in the early stages of it, you only have the virus or the antibodies, and it is not communicable by casual contact. It is communicable by sexual contact or from needles or blood.

Senator GLENN. Do we know that positively?

General BECKER. Not 100 percent.

Senator GLENN. A determination just like you stated there I thought was still a little bit uncertain. You are stating it very positively. Has that been determined, that it is not communicable by any of these other means?

General BECKER. I am sorry to state it so positively. It is my belief that it is that positive. But you are right, it has not been clinically proven to so be, and that is the major problem with AIDS today—the amount of clinical data that we have. We do not have enough to make those kinds of final decisions as yet.

Senator WILSON. All right. Thank you.

Let us move on to some other subjects.

I do not want to dwell on this at great length. We simply have not the time. Before we leave the subject of emergency room care, Dr. Mayer, in order to achieve accreditation, it is not necessary that any hospital offer an emergency room, is it? Some, I gather, of the larger hospitals, are required to have an emergency room. But if we are talking about a small facility, what is the answer there?

Dr. MAYER. That's right. It is not a condition of accreditation for small facilities.

Senator WILSON. Well, the impression that I have gathered, perhaps wrongly, is that some facilities have offered levels of emergency room service that they were not required to offer for accreditation and that they have then not maintained the level of staffing required under the accreditation that they have received.

Is that true?

Dr. MAYER. That could be, Senator. But I really cannot answer that with any accuracy. I would be happy to find out the answer to that for you, though.

Senator WILSON. All right.

[The information follows:]

LEVELS OF EMERGENCY ROOM SERVICE

Levels of emergency room medical services within the Department of Defense (DOD) are classified in accordance with the Joint Commission on Accreditation of Hospitals (JCAH). The JCAH standard states that a well-defined plan for emergency care, based on community need and the capability of the hospital, shall be implemented by every hospital. A hospital's emergency service must be classified according to the level of services provided. The levels of emergency services may range from very comprehensive to a first aid/referral level of care. Specific staffing and general requirements for four levels of emergency services are:

1. Level I: A Level I emergency medical service offers comprehensive emergency care 24-hours a day, with at least one physician experienced in emergency care on duty in the emergency area. There must be in-hospital physician coverage by members of the medical staff or by senior-level residents for at least medical, surgical, orthopedic, obstetrical/gynecological, pediatric, and anesthesiology services. Other specialty consultation must be available within approximately 30 minutes. Nursing coverage requires at least one registered nurse and a sufficient number of other nursing personnel permanently assigned and on duty within the service area at all times. The number of nursing service personnel has to be sufficient for the types and volume of patients served.

2. Level II: A Level II emergency medical service offers emergency care 24-hours a day, with at least one physician experienced in emergency care on duty in the emergency room area, and with specialty consultation available within approximately 30 minutes by members of the medical staff or by senior-level residents. Nursing service coverage is identical to Level I emergency room.

3. Level III: A Level III emergency medical service offers emergency care 24-hours a day, with at least one physician available to the emergency care area within approximately 30 minutes through a medical staff roster. It must also have a registered nurse available on at least an on-call, in-house basis.

4. Level IV: A Level IV emergency medical service may offer reasonable care to determine whether an emergency exists, render lifesaving first aid, and make appropriate referral to the nearest facility that has the capability of providing needed services. The mechanism for providing physician coverage at all times must be defined by the medical staff.

The purpose of using JCAH emergency service standards is to preclude any of our medical treatment facilities from offering emergency room services that are beyond their personnel, equipment, and resource capability. We are currently staffing a proposed Directive on emergency medical services that will clarify these guidelines.

Senator WILSON. General Becker, did you have a response?

General BECKER. Yes; in the Army, yes, that has happened. Emergency rooms were graded—class one, two, three. I am not sure of the exact grading. We go down to four. The auditors found somewhere that this emergency room was supposed to be a one or a two and it was not staffed according to that.

Certainly we have taken every step to correct that. That was a new grading, if I remember correctly, that the JCAH and other bodies have made in the past few years.

Senator WILSON. Is there any particular benefit that attaches to the facility for offering an emergency room at a higher than a lower level?

Dr. MAYER. Not in the service, sir.

General CHESNEY. The primary reason for grading is so that the local ambulance services know which is a grade 1 facility that has a doctor and a shock trauma team in it and everything like that.

Senator WILSON. Well, that makes great sense. I understand that.

The question, though, is why a commander or whoever it is who is responsible for making this decision would, in effect, offer an emergency room standard that they cannot staff.

General CHESNEY. There is no reason to do that. We just declared to JCAH what level our place is and then they come and inspect us on that level.

Dr. MAYER. I don't think any commander would knowingly or voluntarily purport to give a higher level of care in the emergency room than he is capable of staffing to deliver. It could only work to his disadvantage, and, in fact, could result in real disaster.

Senator WILSON. I think so, too. And yet, General Becker has, with admirable candor, responded that they did, through their audit, find in effect levels of exaggerated advertising.

Dr. MAYER. I think that probably, in all likelihood, is a result of having established a certain level of emergency room care and identified that, and over time, as personnel change and as people transfer in and out, without paying close enough attention to what the level was supposed to be, they simply found themselves with insufficient people of the right qualifications to take care of it, and it took an auditor to point that out.

Senator WILSON. General Becker, you are saying that there are recorded instances of the downgrading of the level of advertised emergency room care?

General BECKER. Well, I don't think this was all done with malice of forethought.

What happened was that someone in the system, in the hospital system, had been asked, say, what kind of emergency room do you have, and he said well, we have a two, and the commander, as far as I know, didn't even know that. Of course, the auditors found this and said if you have a two, you are supposed to have this kind of training requirements, this many personnel, and this kind of equipment. It is all laid out very specifically in the regulation and they went right down it. They were very, very good auditors. They audited exactly according to the requirements.

But JCAH had passed all these hospitals. It is the same as the questions Senator Glenn asked about credentials. They would not, let's say, in a packet of credentials, find the internship certificate,

yet find a residency certificate, and say that the packet was not complete—which is true.

Senator WILSON. Is there a requirement now for periodic inspection to determine whether or not the professed level of emergency care is, in fact, available?

Dr. MAYER. That will be part of the new directive on emergency rooms.

Senator WILSON. OK.

General BECKER. We are insuring that they are what they say they are. Some of them we have downgraded to a more reasonable level.

General CHESNEY. Our inspector general does that on his visits.

Senator WILSON. Thank you.

I am going to turn now to questions of peer review and malpractice, and I did not arrange for the choirs of angels singing in the background, outside the door, to heighten the effect. [General laughter.]

Dr. Mayer, let me ask you this. You recently announced that you would seek the use of external peer review organizations to review the operation of military medical care dispensaries in much the same fashion that peer review is now being performed with regard to Medicare.

What will those reviews, in your judgment, do for the military system? I would be interested in the opinion of each of the Surgeons General after you have expressed yours.

Dr. MAYER. These peer review organizations will be made up of qualified physicians, qualified individual specialties. We will provide them with a list of the kinds of thing we would like them to look at as occurring within our hospitals.

The hospital commander in each case will have the option to add things to that if he wishes.

A peer review group on a sampling basis, on a periodic, regular, sampling basis, as is done in all hospitals receiving any Medicare patients, which is about 95 percent of all hospitals, will look for the kinds of things we are asking them to examine. For example, we would want them simply to examine every case of a death in the emergency room, any patient who was readmitted with the same diagnosis over, say, within 14 days of discharge from the hospital.

The existence of those incidents—a death in the emergency room or the readmission of a patient 14 days after discharge—does not, in and of itself, prove anything except that it happened. The peer review groups looks into the chart, looks into the circumstances surrounding that and evaluates what was done for that patient with respect to community standards of care.

When they find deviations from that, if they do, they will report those to the hospital commander—not to the public and not to patients, but they will report it to the hospital commander.

It will behoove the hospital commander, at this point, to determine whether or not his own quality assurance program, which is much more elaborate than anything a peer review group can do, an outside peer review group, whether his own system is in fact functioning, in fact picking up the same kinds of things, and he will then determine what to do about that.

So the introduction of outside civilian peer review people into our facilities I see solely as a way to augment, monitor, and support our own peer review and our own quality assurance program. The reports will be kept totally within medical channels.

Now, over a period of time, as those peer review groups review the same or similar things in the civilian community, it may be possible to establish baseline data for what the expected incidence of, say, wound infection after surgery is, or what the expected complication rate is in obstetrical deliveries or the incidence of low birth weight babies.

Such data does not exist on a national basis in spite of the best efforts of the National Center for Health Statistics, on a basis with which I am comfortable to make comparison.

But we will certainly find out within our own systems what the standards of practice are and what the incidence of morbidity and mortality actually is.

So, it will simply assist us in keeping our own commanders and their superiors up through the Surgeons General a close watch on what is happening, both with our quality assurance program as well as the quality of care actually being delivered in the hospital.

And I would not have done it had I not believed that it would both give some additional vitality to our own quality assurance activities and give us the benefit of the consultation of our civilian colleagues who have great skill and with whom we are frequently in intimate contact.

Senator WILSON. Before I solicit the opinions, like or different, of the Surgeons General, it would seem obvious that institution of a program of this kind, unless they discover manifest differences with the quality assurance programs internally, will do a great deal to enhance the credibility of military medicine.

Dr. MAYER. I hope so.

Senator WILSON. Gentlemen, is there anyone here with a like or different point of view?

General BECKER. I have been talking so much, maybe one of these other fellows would rather go first, although, of course, I don't mind. [General laughter.]

We welcome peer review, and our books are open. We welcome this.

Now, we have some concerns about it. One of the concerns that Dr. Mayer spoke about is that there is no good denominator out there to compare us with. These people are going to review quality of care rather than utilization review, like they do for Medicare. They are going to review a different thing.

What we want to come out of this is are we as good as, better than, or worse than civilian hospitals? What is the standard of the day?

We believe we are better than civilian hospitals but we won't be able to prove it with this review until a great body of data is collected in the civilian sphere.

Also, we hope, and I believe that that is what is planned, that practitioners who are active practitioners in like communities or in the surrounding communities be used for this peer review. To take someone who has been retired for 20 years or who has never practiced to make this review, we can have more big stories in the

papers which are not really based in fact. We want it to be a good, clean review.

General CHESNEY. To paraphrase Mr. Churchill, never have so few been reviewed by so many so often. [General laughter.]

Air Force medicine has had 106 GAO, DOD, and Air Force reviews in the last 2 years. We also have our inspectors general who go out to every hospital every 2 years, and the Joint Commission of Hospital Accreditation, and also our major command staff officers review each of our hospitals at least annually.

So our hospitals are looked at very closely. But they are not looked at by professionals in a peer review sense.

The other auditors primarily look at numbers and whether we are following regulations and that sort of thing.

So this will work and it will be a help.

Senator WILSON. Admiral Seaton?

Admiral SEATON. I agree with what has been said before, and the only thing I would add is, I think it will replace anecdotal comment and beliefs and personal opinions by a formal formatted civilian-oriented review of what the quality is. I welcome it as an adjunct to our inplace Q–A system.

Senator WILSON. This is something that we can pursue at greater length for the record, and maybe Mr. Gilliat will have some response.

Dr. Mayer indicated that he foresaw, he anticipated, the functioning of this peer review with reports eventuating to the hospital commanders rather than to the public. My guess is that that would be discoverable under the Freedom of Information Act. I think that this is going to be available to the public.

Mr. GILLIAT. I would agree, Mr. Chairman. It would be difficult to withhold it under the Freedom of Information Act, to the extent it was factual. To the extent it involved opinion or evaluation, I think it could well be protectable. It may be protectable as expert evidence. I don't know. We have not fully explored that.

Senator WILSON. Again, because of the passage of time, I will simply ask this next question for the record, but I think it is an important question.

By analogy to what we are experiencing in an unrelated field, that of defense acquisition procurement, some doubts arise in my own mind as to whether or not the price of all of this audit and investigation isn't, at the very last, the consumption of a very considerable amount of time and energy on the part of those being audited.

Now, it may very well be worth it. I am inclined to think that it is. In the case of those who are providing hardware, which is why there is no analogy, I have a suspicion that we ought to engage in a couple of experiments to release those people and see what the quality of the hardware is as compared with the people who are undergoing the intensive audit.

The only analogy that I would suggest is that this is going to impose an administrative burden.

For the record, Dr. Mayer, I would be interested in how that particular problem is being addressed. I do not imply even a criticism. I think this is a good idea, a very good idea. It will substantially enhance the credibility and I think for that reason it is worth it.

But I think it is going to impose some new requirement and therefore some difficulties.

[The information follows:]

EXTERNAL PEER REVIEW PROGRAM

The DOD external peer review program to be initiated early next year will be conducted by a civilian contractor. The Military Departments and the individual military medical treatment facilities will be required to provide minimal personnel to assist in the peer review process. Their primary responsibility will be gathering and reproducing patient records for those who will actually conduct the review. The contractor's personnel will conduct the quality of care medical reviews or patient's records. Results of these reviews will be processed through the existing quality assurance system within each medical facility.

We believe that this minimal added workload is a small price to pay for the projected quality assurance benefits we anticipate from the peer review system.

Senator WILSON. Let's turn now to malpractice, although we will get into this a good deal more next week. While this panel is here, I want to afford you the opportunity to comment.

Dr. Mayer, do you have any objective comparisons between the incidence of malpractice in the military system as compared to malpractice in the civilian sector?

Dr. MAYER. Yes, we do, sir.

First, it has to be understood that most claims against physicians for malpractice or accidential, untoward outcomes never reach the public attention. Every physician in practice today for practical purposes pays very handsomely for very expensive malpractice insurance, up to and exceeding $100,000 a year in some instances, in some specialties. And when a patient makes a claim, the claim, more often than not, it is my understanding, certainly never gets to court or to any kind of public attention but is negotiated between the attorneys for the malpractice insurance company and the attorneys for the claimant.

Senator WILSON. I think it would probably be more accurate to say it gets to court, but not to trial.

Dr. MAYER. It may not even get to court, let alone to trial.

By contrast, every action, every complaint against the military health care system is a matter of public record and frequently a matter of public attention. But at least we have a record of all of those, whereas we only have what I think are very incomplete figures from the civilian community as to the number of malpractice actions.

For a comparison, remembering that 80 percent of the patients that we treat are in no way prohibited from suing the government for any medical mischance. Even if we allow for the 20 percent who are in uniform cannot at this point file any kind of formal action, the rate of claims of malpractice or substandard practice against members of the military medical profession is well under half of what it is in the civilian community. Those figures are firm, and we can show them to you.

Senator WILSON. I would like you to do that.

I would ask you to provide for the record the data on which you base these comparisons.

Dr. MAYER. Yes, sir.

I would be very happy to.

[The information follows:]

MALPRACTICE CLAIMS

The rate of malpractice claims filed in connection with military medical care remained about the same in fiscal years 1983 and 1984 at around 6.4 claims per 100 physicians. Estimates for the civilian sector in 1984 indicate an overall rate of 16.3 claims per 100 physicians. The claims rate data for the military system were derived from an internal reporting system on malpractice claims; civilian data are from the database of St. Paul Fire & Marine Insurance Company, St. Paul, Minn., one of the Nation's largest underwriters of malpractice insurance. Adjusting the military rate upward to take into account the fact that active duty personnel cannot sue the government for injuries incident to or arising out of their military service, would result in an estimated military rate of 8.7 claims per 100 physicians or about one half that of the civilian rate.

Senator WILSON. In the analysis that you have made, do the data that you have, allow you to assign malpractice claims—and I'm using "malpractice" not in any technical or legal senses, but in terms of less than adequate medical attention—can you separate those made in the treatment of active duty personnel from those from the other cases?

Dr. MAYER. Technically active duty personel cannot file actions for malpractice.

Senator WILSON. I understand that.

Dr. MAYER. So we really don't have such a record. We only have a record of the other 80 percent of our patients.

Senator WILSON. OK.

Is there no basis of complaint? Is this just a body of nonexistent data?

Dr. MAYER. There is a basis, I suppose, in that there is nothing to prevent the soldier, sailor, or airman from complaining to the inspector general, which he is completely privileged to do in complete protection of his privacy. But there is no evidence at all that somehow our doctors treat the 20 percent of their patients who are in uniform different from the 80 percent who are not.

In fact, when you have a bunch of patients on bed in the ward, it is really fairly immaterial to the doctor whether the patient is in uniform or not. He is just a patient.

Senator WILSON. I am inclined to agree with that, although I have to ask you since there really are no data that represent claims of the active duty personnel, we really don't have any basis, other than inference.

Dr. MAYER. Well, we have the statistical probability of the fact that 80 percent of our patients can sue us.

It just defies belief that 20 percent, by virtue of being active duty, are somehow treated differently by the same doctors, on the same day, in the same ward, than the patients who are not in uniform.

Senator WILSON. There is really no evidence either way, is there?

I am inclined to agree with you. But there is no evidence.

Dr. MAYER. But there is statistical probability.

Mr. GILLIAT. Mr. Chairman, the information that we have produced, largely by extrapolation, was based on those who can bring actions. But of course there are other investigations done in response to active duty military personnel who complain about inappropriate care, and they can trigger such things as the Navy's JAG Manual investigation, which is a thorough investigation of the circumstances, made available, generally speaking, to the person

making the complaint. But it is only recently that we have been attempting to gather and relate this information to the other data that have been collected on the actual claims and malpractice actions.

Senator WILSON. Incidentally, I want to offer to the Surgeons General and to Dr. Mayer the opportunity to either appear or to be represented next week when we are going to hear of the complaints of those who feel that military medical care is not adequate and those who are supporting legislation that would give active duty personnel the same right to sue for malpractice as those not in uniform.

Dr. MAYER. Thank you very much, Senator. We would appreciate that opportunity.

I would just implore everyone who listens to some of these terrible, sad, tragic cases, to recall that the overwhelming majority of the other 56 million outpatient visits we see a year and 1 million admissions do not result in such tragedies, and put it into some kind of perspective.

That is a problem in medical malpractice actions in civilian courts, of course. You always get a jury, because it is very easy for the members of the jury to identify with the patient, if not overidentify with the patient, and the result has been a tremendous escalation in malpractice awards that are just absolutely beyond belief.

I think that may be stimulating some of the people who would like to be able to sue the Government for malpractice, because our compensation system does not reward people of the way that some civilian courts have done with millions of dollars for pain and suffering.

Senator WILSON. That is quite true. That is certainly the municipal experience in the interval that has elapsed since the removal of the protection to them of the doctrine of sovereign immunity.

Let me ask you, Dr. Mayer, this question. It seems to me that your diverse, broad, and rich experience in the medical profession, having been in private practice, having been in military medicine, and now from the vantage-point of being the Assistant Secretary of Defense for Health Affairs gives you a perspective that those with less experience could not have.

In your view, should there be a similar right available to those in uniform to bring suit for alleged malpractice?

Dr. MAYER. I can only answer that from the standpoint of my impression of what effect it would have on the quality of medical care. I am not specially qualified to make a judgment as to the equities involved or the civil rights involved or the due process involved.

As far as the effect, whether that other 20 percent of our patients could sue our doctors or not, on the quality of health care in the Armed Forces in my judgment is that it would have no effect whatever. It will not result in improved health care.

The doctor who is even remotely worthy of that professional title, who judges the way he treats a patient based on the fear that somebody might sue him, is not worthy of being in the Armed Forces, and we don't have doctors like that to the best of my judgment.

I cannot imagine that the fear of being sued by that 20 percent who now cannot sue could have any possible effect on the quality of care. It will not improve it—which is not to say that it needs that much improvement. I do not mean to imply that.

In my judgment, that is simply not a way to guarantee quality or even to impact quality.

Senator WILSON. Do you think it will stimulate, as I think it has clearly in the private sector, a caution and a defensiveness that would bring about far more tests, far more procedures being prescribed, in a sort of record-making way?

Dr. MAYER. I suppose that it would

It would not be natural for people not to defend themselves if they thought they were in jeopardy. But, once again, our doctors are in jeopardy now. Any patient who sues for malpractice, who is allowed to do that—the 80 percent, the dependents, the retirees, their dependents and their survivors—when they sue, that doctor is in the spotlight. That doctor is likely to be hauled into court, held up as an example. He is then subject, if something does come up that indicates that his practice has been bad—he doesn't pay money. He doesn't have any money to pay anyway. We don't pay doctors that much.

But, what is going to happen is that he is in terrible jeopardy. His career is on the line. He is liable to be punished in other ways. Look at what is happening in the case that I cannot mention now.

Senator WILSON. If you don't mention it, I won't look at it. [General laughter.]

Dr. MAYER. Seriously, I just cannot believe in the reasoning of people who think gee, if you just threaten them with lawsuit, they are going to do better. That they would increase the amount of defensive medicine they practice, as has happened in the civilian community, I would rather doubt, in the military service. There is nothing preventing a doctor in any hospital in the military that I know of from ordering any test, any diagnostic procedure that he thinks is necessary for that patient's benefit.

So I don't think that allowing 20 percent more people to sue him is going to get him to order a whole bunch of additional lab tests, CAT scans, and so on.

The phenomenon is different.

Senator WILSON. General Becker, did you want to respond?

General BECKER. Yes, sir.

The Gonzalez Act, as you know, protects physicians from having to pay any malpractice. So, in fact, if the *Feres* doctrine is broken down, it would not result in the direct suing of military physicians. The breaking down of the *Feres* doctrine and the problem with the bill that Senator Sasser has on that is certainly way beyond my scope.

Dr. MAYER. I was just going to say that.

Senator WILSON. The response that I wanted from you was precisely what Dr. Mayer made, at least directing his response to the question of the effect it would have on health care.

We are going to look to Mr. Gilliat to provide us with a response on the legal niceties, we will wait until next week to do that. If you wish to unburden yourself in writing between now and then, we would be delighted to get it.

Mr. GILLIAT. I already unburdened myself to the tune of 14 pages in my prepared statement.

Senator WILSON. Yes, you have.

Before we conclude, I hate to do this. It is very easy for a chairman to casually toss off a requirement for the record that imposes great labor upon the witnesses. But we are just out of time. We have dwelled upon a number of specific concerns. But I don't want, in closing this meeting, to ignore a rather basic policy consideration, and that is the one that Dr. Mayer has touched on, and that is his expressed concern, which I share, as to the capacity of the military health care system to perform these two disparate roles, that of wartime care and that of peacetime care.

He has stated that he has a great concern as to whether or not the system can perform both these missions. I know that we have not given the time that that question requires, and I am going to ask that each of you, with the notable exception of Mr. Gilliat—since the Surgeons General are not required to answer legal questions, we won't ask him to answer medical ones—respond to that and, in doing so, to suggest as best you can how you think that we can, if required to focus upon the wartime priority, discharge in a different fashion that we have the obligation we have to military dependents and the dependents of retirees.

I will ask that you do that for the record.

[The information follows:]

WARTIME VERSUS PEACETIME CARE

ARMY

As you know, our primary obligation and priority is our wartime medical mission. But we also have the obligation and duty to provide the best quality peacetime medical care to our soldiers and their families. Properly designed, the military health care system can meet both of these roles with the peacetime mission supplementing and enhancing our ability to perform our wartime mission.

As has already been mentioned, several alternatives to supplement our present peacetime organization are being tested; Health Maintenance Organization (HMO) contracts, the Fort Ord CHAMPUS catchment area project, fixed price contracting for psychiatric care, and others will be pursued. On 1 October of this year we opened a contractor operated primary care clinic in Northern Virginia. If successful, this concept will be extended to other geographic areas. Contracting for personal services is an innovation that has been a great help in meeting our peacetime obligation, and greater use of this authority is already underway.

We are also replacing active duty general medical officer positions with family practice positions. This action will have a positive impact on medical readiness by providing the Army with a more highly skilled physician force while simultaneously enhancing our ability to meet peacetime health care obligations. We are still facing a shortage of ancillary support and have the support of the Army staff in correcting this problem.

This task is not an easy one and no simple solutions exist. However, by trying different solutions and pursuing innovative programs we can discharge our dual obligation to wartime readiness and peacetime health care.

NAVY

The Navy Medical Department is capable of carrying out both our wartime readiness and peacetime medical care missions. These missions must remain fully integrated in order to ensure appropriate peacetime training and efficient peacetime-to-wartime transition. As Dr. Mayer has indicated, our wartime readiness mission must be given highest priority.

Navy programs active duty medical personnel billets to fulfill wartime mobilization requirements which are utilized for the delivery of peacetime health care. The present population of active duty medical personnel is the cornerstone of Navy's

ability to provide combat casualty care quickly in time of war. Use of active duty personnel in peacetime medical practice develops the teamwork required for war, matures and maintains their medical skills, and updates medical materiel support to a state-of-the-art status.

Medical personnel accession, training, and retention in peacetime is directly related to their ability to exercise a full spectrum of medical skills. Young, healthy people found in military service do not provide a population which will challenge and maintain professional skills. Active duty populations are screened to eliminate medical disabilities. A lack of daily medical challenges will adversely effect not only medical readiness but the retention levels of physicians, other health care providers, and ancillary personnel as well.

Medical training programs demand a full spectrum of medical care for approval by accrediting agencies. The retired and dependent populations constitute two important patient groups in which cancer and congenital defects require skills akin to the treatment of war-related injuries. Surgery and anesthesia training programs, which teach wartime related skills, require support from other programs not normally considered war-related in order to be accredited; internal medicine and pediatrics are part of a full medical schedule for training required by the surgical and anesthesia resident. Without adequate medical programs and challenges, negative effects will ripple through the procurement mechanisms. Scholarships, the dominate mechanism for recruitment of physicians, will attract fewer qualified applicants of the caliber now entering the system.

Developing a large-scale alternative health care system for other than active duty personnel and jeopardizing the Navy's medical mobilization and readiness mission by elimination of the peacetime patient practice needed to enhance and maintain wartime medical skills is counter-productive.

We are studying alternate ways in which cooperative efforts between the services and CHAMPUS may enable us to deliver quality care to the greatest number of eligible beneficiaries. We are participating in a catchment area demonstration project which will determine the feasibility of assigning area hospital commanders the resources and full responsibility for a defined beneficiary population. These alternatives to CHAMPUS should be decided by financial, patient satisfaction and quality of care criteria. Dependence on alternative forms of care should not deplete the Navy Medical Care System of the patient care beneficiaries most needed to maintain wartime skills.

AIR FORCE

The Air Force Medical Service is structured to support both its peacetime and wartime missions. These two missions are not mutually exclusive but, in fact, are inseparably linked. The peacetime mission sustains the health of the active duty force in peacetime and provides the medical resources needed in wartime. In this regard, military medicine is unique because medical personnel produce a significant peacetime economic benefit by performing their professional skills which will be needed in wartime. The peacetime direct care system is supplemented by the CHAMPUS to support the total health care requirement for all beneficiaries. During the last five years, the Air Force has achieved substantial progress in the readiness arena; however, there is still much to be done. As of the FY86 President's Budget, the Air Force can support 61 percent of its wartime medical manpower requirement and 43 percent of its contingency beds requirement. The Air Force requires a large active duty medical force to support its wartime mission because when a contingency occurs, Air Force casualties peak within 15 days and the medical force must be immediately ready to deploy overseas to treat those casualties.

During peacetime this active duty medical force is gainfully employed by providing health care to eligible beneficiaries in the peacetime direct care system. This provides sufficient patients with a broad spectrum of medical and surgical diagnoses to enable physicians to maintain proficiency for their readiness mission. If Air Force physicians had to restrict their practice to the treatment of mainly the active duty force, this young and healthy population would not provide sufficient numbers or type of diagnoses necessary for physicians and nurses to maintain their skills needed for wartime. The treatment of dependents, retirees, and other eligible beneficiaries enhances Air Force readiness by providing a system with different levels of care ranging from primary care at clinics to tertiary care at medical centers for complex medical and surgical cases. Wartime medical support of a conventional war demands a heavy emphasis in surgical skills whereas the peacetime mission requires a more balanced combination of the various medical and surgical disciplines. If the enemy employs nonconventional weapons, the required wartime specialty mix

would shift from a surgical to a medical emphasis. Due to the long lead time it takes to develop trained medical manpower, the Air Force must maintain a certain degree of force flexiblity. This planning flexibility is directly related to our wartime specialty skills substitution program. We place great potential value on the ability of surgical specialists to substitute for one another and on the broad capability of our medical officers including flight surgeons to assume some surgical roles. For example, obstetricians and gynecologists are trained in abdominal surgery techniques and in wartime would be utilized in that role; pediatricians would effectively provide second echelon emergency skills such as triage, resuscitation and patient stabilization; and internal medicine physicians would manage intensive care and post operative care units to free surgeons to spend their fulltime in the operating room. All Air Force physicians are being trained to high levels of advanced trauma life support skills and military medicine knowledge. Air Force Medical Service leaders exercise professional judgment in assigning job substitution among members of the Medical Corps. The Air Force Medical Service is structured to achieve the efficiencies that can be gained by using the active duty medical force to treat all categories of eligible beneficiaries as a means of maintaining specific skills while at the same time minimizing the financial impact of additional CHAMPUS workload. The alternative would be to create a military health care system that is focused only on the wartime required specialties as they are defined today with a strong surgical emphasis. If the Air Force focused only on its wartime mission, additional resources would be required to discharge our responsibilities to peacetime beneficiaries who require non-surgical health care services. This could only be accomplished by contracting for additional civilian health care providers or increasing the CHAMPUS program both of which would be expensive alternatives. The Air Force plans to meet both its peacetime and wartime mission requirements by providing a balanced medical force and judicious wartime job substitution.

Senator WILSON. We are past the time that I had thought would be required, although obviously the number of hearings that we are engaging in reflects the importance that we attach to this entire question of the military health care system.

Again, gentleman, we are in your debt. The responses that you have provided and will provide are singularly useful.

So we thank you. The invitation exists. I hate to take so much of your time, though I do not hesitate to ask you for it because of the importance that we do attach. On October 8 the hearing will be on this same subject. We are having a separate hearing to afford the critics and independent analysts of the system, rather than those who are direct participants in it, the opportunity to have their say. But we will welcome you here as observers or as participants.

Thank your very much for your contributions this morning.

Dr. MAYER. Thank you, Senator. We appreciate it.

[Questions with answers supplied follow:]

QUESTIONS SUBMITTED BY SENATOR JEREMIAH DENTON

IMPROVING CHAMPUS REIMBURSEMENT TIMES

Senator DENTON. Can CHAMPUS payments to reimburse families that have paid for reimburseable medical care be speeded up? If so, what general steps are being taken? When can improvement be expected? How can CHAMPUS be made better overall?

Dr. MAYER. Some additional improvement in timely payment of claims is possible. Avoiding delays is a major concern of ours. Dramatic improvements have been made in the timeliness of payment in the past few years. In 1985, three out of four claims are processed in 21 days, or less, which compares favorably with civilian health care plans. Six years ago, we were able to process fewer than one out of two claims in 21 days. This significant improvement has taken place despite an increase in claims of more than two million.

The steps that have led to this improvement have involved major changes. Claims processing operations have been regionalized for greater efficiency and our claims processing contractors operate under tight performance standards that are strictly enforced. A contract performance incentives system is being used, which has result-

ed in collection of $767,824 from fiscal intermediaries for substandard performance and awards of $124,330 for exceeding standards. We have declined to exercise contract option periods and have recompeted contracts because of failure of the contractor to meet performance standards.

In general, most payment delays now occur for one of two reasons. First, claims that involve complicated or unusual care require additional information from the hospital or physican for adequate medical review. We are applying various ways to reduce the time in processing these "problem" claims, but prudent management to assure the quality and medical necessity of care will always result in some payment delays in specific instances. The other circumstance that can lead to payment delays is a transition from one claims processing contractor to another at the time of a new contract award. We are managing this process much more tightly than in the past to help the incoming contractor avoid claims backlogs while it is in the start up period of a new contract.

Some of our health care demonstrations, such as the Health Maintenance Organization (HMO) demonstrations, avoid completely the problem of payment delays. Our HMO enrollees submit no claims and do not have to request reimbursement.

A key component in reducing payment delays is increasing the number of providers who agree to participate in CHAMPUS by submitting the claim directly and billing the patient only for the cost-share amount. Virtually all hospitals participate in CHAMPUS, and our rate of participation for physicians and other individual providers is rising. Currently, individual providers participate on about 50% of the claims we receive. One of the ways we are attempting to increase this is by making claims submission less burdensome for the provider by adopting claim forms that are uniform for the entire insurance industry. We adopted a uniform hospital claim form this year and are working with a group of private and public insurance organizations to develop a uniform claim form for doctors' services.

COST OF THE MISSION

Senator DENTON. Is $10 billion enough for the mission? What general definition of mission can be considered adequately financed by $10 billion for wartime and/or peacetime requirements?

Dr. MAYER. Given the current climate of fiscal constraint, I can only say that approximately $10 billion is sufficient to support those activities currently included in our "Cost of Medical Operations" calculation.

With our renewed emphasis on wartime medical readiness as our highest priority, we are carefully examining just where our resources are expended and whether we are financing both our wartime and peacetime mission capabilities for the best price.

As we make progress toward our goal of becoming truly medically ready to deal with wartime casualties, adjustments to the $10 billion figure may need to be made. Some of these adjustments will come in the form of a shifting of resources within the $10 billion, but there is the distinct possibility that additional resources will be required to adequately fund our mission.

QUESTIONS SUBMITTED BY SENATOR JOHN GLENN

ORGAN TRANSPLANTS UNDER CHAMPUS

Senator GLENN. The House version of the fiscal year 1986 Defense Authorization bill included a provision that would have authorized CHAMPUS to cover non-experimental organ transplants. This provision was not included in the final conference agreement on this bill. What is the current CHAMPUS policy on reimbursement for organ transplants? In your view, what changes in this policy would come about if the provisions proposed by the House were enacted? What would be the projected annual cost?

Dr. MAYER. The current CHAMPUS policy is to provide benefits for covered services in connection with non-experimental organ transplants. This includes coverage for kidney, liver, corneal and some marrow transplant procedures, as long as they are performed in accordance with accepted professional medical standards. In arriving at a determination as to whether a given organ transplant procedure is investigational or experimental, we consider technology assessments by the Public Health Service, Health Care Financing Administration policy, and the policies of major health care care insurers.

If the provisions proposed by the House were enacted, it would not change our current policy, and no change in our costs would occur.

DEMONSTRATIONS ON CHAMPUS ALTERNATIVES

Senator GLENN. Dr. Mayer, can you describe any current experiments you have to examine more cost-effective or competitive alternatives to CHAMPUS, such as HMO's, to provide care to DOD beneficiaries? Do you think we should expand these experimental programs to a broader scale?

Dr. MAYER. CHAMPUS is conducting HMO demonstrations in the Portland, Oregon; Houston, Texas; and the Minneapolis/St. Paul areas. In these areas beneficiaries may choose to enroll in a local HMO as an alternative to CHAMPUS. Expansion of these demonstration to other areas awaits the results of an evaluation study which is currently being developed.

In the Portsmouth, Norfolk, Newport News, Virginia area, a contract provider arrangement will be tested beginning October, 1986. Under this arrangement, a single contractor will accept a fixed price to provide all CHAMPUS mental health services in the area. These services will be provided through a network of providers, in both institutional and ambulatory settings. The demonstration will include a comprehensive case management system to ensure cost-effective utilization of services while maintaining quality of care. It is anticipated that this fixed-price contract, arrived at through competitive bidding, will provide a powerful incentive to reduce costs through the selection of less costly treatment alternatives and avoidance of overutilization of services. A separate contract will be let to monitor the quality of care provided during this demonstration. The Tidewater area was selected as a site for this project because of the relatively high mental health costs CHAMPUS has experience there over the past several years.

During the coming year three "catchment area demonstrations" will take place, one sponsored by each of the military services. In these demonstrations, a local military facility (MTF) commander will be given responsibility to provide for all authorized medical care for the beneficiaries in the MTF catchment area. The CHAMPUS funds which would have been spent in the area will be made available to the MTF commander through an interagency transfer. It will then be up to the commander to decide which services to provide at the MTF and which in the civilian community. For services to be provided in the civilian community, the commander is expected to take advantage of competitive forces in the market place and enter into cost-effective contractual arrangements with local provider groups.

An important feature of these demonstrations is the enrollment of beneficiaries in the local medical care program or programs offered by the MTF commander. This will allow for keeping track of who receives what kind of care from which sources, thus providing better organization and control of the local medical care system.

The Army catchment area demonstration will take place at Fort Ord, California. The project protocol has been approved by my office and will be implemented within the next few months pending finalization of detailed plans. The Air Force is developing a demonstration at Nellis Air Force Base in Nevada, and the Navy has selected Newport, Rhode Island as the site for its catchment area demonstration.

Another demonstration, which will begin next month, is the centralized management of bone marrow transplants by Wilford Hall Air Force Medical Center in Texas. In this demonstration Wilford Hall's bone marrow transplant team will evaluate and monitor the care of all Uniformed Service beneficiaries who are candidates for allogeneic bone marrow transplants. it is anticipated that most of the transplantations under this program will be done at Wilford Hall, at an estimated savings to DOD of over $6,000,000 in the first year of the project. This experiment in the centralized management of a low volume, high cost surgical procedure may point the way for similar programs in other areas.

While we do not intend to expand the particular demonstrations I have just discussed until they have been fully evaluated, we do intend to employ some of the concepts of these demonstrations in a broad range of system changes we are currently considering. Regardless of the results of the small scale demonstrations currently under way, it seems clear to me that in today's competitive health care market place, we can provide the same or better health care benefits to our beneficiaries at a lower cost by moving from our current method of reimbursement for billed charges toward negotiated contractual arrangements with civilian providers of care. We intend to keep moving in this direction.

GRADUATE MEDICAL EDUCATION

Senator GLENN. The recently completed Report of the Blue Ribbon Panel on Sizing DOD Medical Treatment Facilities recommended that the military services' in-house physician training programs should be sized on a specialty-specific basis,

and residency and other graduate medical education programs should be justified on readiness requirements.

Do you think the services' intern and residency training programs meet these criteria now?

Dr. MAYER. No, they do not at the present time. Physician training programs are closely aligned with the military medical force structure. That force structure is determined by the nature and type of direct care services provided to military beneficiaries. The current direct care system has been designed to provide care to approximately two million active duty military personnel and nearly eight million dependents and retirees. The press to provide comprehensive care to such large numbers of nonmilitary beneficiaries has resulted in a heavy peacetime care emphasis requiring a specialty mix of personnel and training programs that differs significantly from our medical readiness needs.

SURGICAL SPECIALTY TRAINING

Senator GLENN. In light of the testimony at our last hearing that surgical specialties represented the most serious shortfalls in each service, I was surprised to learn that surgical specialties (surgery, orthopedics and anesthesiology) represent less than one-quarter of your total residents and fellows trained in military medical facilities.

According to figures in the Report of the Blue Ribbon Panel on Hospital Sizing, the Army trains 24% of its in-house residents and fellows in surgical specialties; the Navy, 25%, and the Air Force only 17%.

If surgical specialties represent the greatest and most critical physician shortfalls, why aren't your in-house training programs geared to producing more physicians in these specialties?

Army

General BECKER. In surgery and orthopedics, the number in training is limited by the Residency Review Council (RRC) of the respective specialty. The RRC is controlled by the American College of Graduate Medical Education (ACGME), which is composed of the American Board of Specialties, American Hospital Association, American Medical Association, Association of American Medical Colleges, and the Council of Medical Specialties Society. The ACGME sets the guidelines for the number in training in military and civilian hospitals. Presently, the Army is authorized to train 24 in surgery and orthopedics.

Anesthesiology training numbers are not established by ACGME. However, they did establish the standard for one staff member for every two in training. Therefore, in order to increase the number in training the Army would need to increase staff, which would reduce the numbers authorized in other specialties. The Army is presently authorized to have 101 anesthesiologists, with an input of 18 per year to meet the authorized output by 1989. Anesthesiology does continue to experience unexpected losses, so input is adjusted to meet the authorized strength.

Navy

Admiral SEATON. True, the Navy trains about 25 percent of its residents in surgical specialties. This 25 percent is driven by the teaching requirements to properly train residents in the surgical disciplines. The American Council on Graduate Medical Education (ACGME) minimum requirement for general surgery training programs states that an accredited program in internal medicine, pediatrics, or family practice be included in the same facility. However, the ACGME further states that it is desirable (and the general rule at the better general surgery training programs is) to have several primary care residencies plus obstetrics and gynecology, pathology, and radiology programs. In addition, residencies in the surgical subspecialties contribute to the quality of the surgical program. Anesthesiology requires a broad experience in all types of surgical procedures plus adequate exposure to specialized areas of pediatrics, obstetrics, and intensive care medicine.

Our figure of 25 percent closely approximates that of one of the largest surgical specialty training programs in the United States, the New Jersey Medical School in Newark, New Jersey. They train 509 residents of which 123 are in the surgical specialties, that is 24.2 percent of their residents.

Air Force

General CHESNEY. Residency man-years are determined and limited by the authorized active duty endstrength and the selection of residents for training is based

on this endstrength. Increasing the number of residents in surgical residencies is limited by the patient mix available, the availability of qualified physician teachers, and the policies of the civilian certifying organizations. Given our current facility limitations and the constraint on peacetime physician endstrength, our in-house and deferred training programs will produce sufficient numbers of surgeons and anesthesiologists to meet our peacetime goals for these specialities. Orthopedics may be slightly undermanned for the next few years. However, our attempt to expand in-house orthopedic surgery was unsuccessful. Due to limited resources, the Accreditation Council of Graduate Medical Education (ACGME) has not allowed us to expand training in this specialty. Air force teaching facilities have maximized their surgical specialty training programs given ACGME program size accreditation, and the physical constraints (size, support personnel, and beneficiary population). Because of limited in-house capability, the Air Force defers a large portion of its Health Professions Scholarship Program (HPSP) graduates for specialty training in civilian institutions and upon completion of the residency they enter the Air Force as fully trained specialists. This program is now producing specialists in surgery, orthopedics and anesthesiology. Medical students are encouraged to apply for the critical wartime specialties, such as orthopedic surgery and anesthesiology. This program has had considerable success. However, there are limitations based on the number of physicians applying for a given surgical specialty and the positions available within the armed services and civilian facilities. Our ability to use surgeons during peacetime is limited by the peacetime population and the number of suitable facilities and supporting personnel. Because of these limitations, any significant increase in in-house surgical training will result in a supply of surgeons that cannot be used productively during peacetime. Currently, the Air Force is sponsoring 26 anesthesiology residents with an additional 56 in a deferred category; 20 sponsored orthopedic residents, 68 deferred; and 229 sponsored surgeons, 263 deferred.

GRADUATE MEDICAL EDUCATION

Senator GLENN. Secretary Weinberger said recently "I see no need to perpetuate any system that produces an oversupply of physicians whose specialties are not relevant for our fighting forces in their time of greatest need."

Are there any plans in DOD to restructure the graduate medical programs in military hospitals to eliminate training programs for physician skills that would not be needed in wartime?

Dr. MAYER. There are plans for examining the military medical force structure to determine what steps may be required and are feasible to bring it in line with the specialty mix and composition required to support our wartime mission. The graduate medical education programs, which are of necessity patterned after the force configuration, may also change depending on what we find out about the overall force structure.

PERSONNEL SHORTAGES

Senator GLENN. I noticed that last month the Commander of Walter Reed closed down 10 percent of his hospital beds because of personnel shortages, particularly nurses and other support staff. Are these same personnel shortages affecting other Army hospitals? How many other Army hospitals have reduced their capacity because of shortages of medical personnel?

General BECKER. The personnel shortages that affected Walter Reed Army Medical Center have affected other Army hospitals (nurses, medical support personnel, physician specialty shortages). Seven other Army hospitals have reduced or curtailed services (beds, clinic visits, procedures, ect.).

Senator GLENN. Admiral Seaton, according to your statement the Navy expects to correct your current physician specialty mix problems over the next few years. What percentage of the Navy's wartime and peacetime requirement of orthopedic surgeon, general surgeons, and operating room nurses do you currently have, and how exactly do you plan to correct these shortages?

Admiral SEATON. Please see chart below.

	Percent of fiscal year 1986 constrained wartime requirement [1] ACDU/RES	Percent of authorized billets [2] ACDU/RES
Ortho surgery	77/38	94/34
General surgery	50/45	93/50
Operating room nurses	80/22	89/33

[1] Based on deployable systems to be on line in fiscal year 1986.
[2] Onboard active duty as of September 30, 1985 and Reserve as of August 31, 1985.

We are taking the following steps to correct these shortages:

(1) Targeting recruiting goals for physicians toward orthopedic and general surgery and other undermanned specialties where applicable.

(2) Maximizing general surgical and orthopedic positions in Navy residency programs. (Active duty in training; general surgery—55; orthopedic surgery—55.)

(3) Managing the Navy Active Duty Deferral Program (NADDS) to allow deferments to the Health Professions Scholarship Program graduates who wish to train in orthopedic and general surgery residences. (81 surgical residents in training through 1991; 83 orthopedic residents in training through 1991.)

(4) Developing surgical specialty substitution criterion by analyzing casualty requirements.

To meet Reserve requirements of these critical specialties we are targeting flexible reserve component programs to attract and retain critical health care specialists. These programs include:

(1) Physician Reservists in Medical Universities and Schools (PRIMUS) which authorizes flexible drills at medical nursing schools for critical specialists such as, orthopedic and general surgeons, and operating room nurse reservists. This program allows reservists to earn pay and retirement credits for training at medical institutions.

(2) Reserve Flexibility (REFLEX)—This program provides physicians with opportunities to receive Reserve pay and retirement credits for participation in equivalent medical training, such as performance of surgical duties related to their wartime role, attendance at health education activities, and other practical surgical experiences.

(3) Using in-house training to train Reserve operating room nurses.

Senator GLENN. Admiral Seaton, in recent years all three services have begun using physician assistants in their medical programs. I understand the Navy recently decided not to bring any more physician assistants into the Navy. What is the reason for this decision? Is there no longer a useful role for physician assistants in the Navy medical system?

Admiral SEATON. The physician's assistant (PA) program was established during the early 1970's to help alleviate severe physician shortages, resulting from elimination of the draft. As physician extenders, the PA's bridged the gap between the demand for direct health care services and that which could be provided by available physicians. The PA's met this challenge in an admirable manner however, the circumstances which prompted the establishment of this program no longer exist. Effective recruitment procedures and well developed training programs have allowed the Navy Medical Department to meet its authorized numbers of physicians. Forecasts indicate availability of adequate numbers of physicians into the 1990's. The steadily increasing wartime requirement for fully trained physicians and the availability of fully qualified physicians override benefits derived from the PA program. The newly established quality assurance guidelines also significantly limits the utilization of physician assistants.

DISCONTINUANCE OF PA'S

Senator GLENN. General Becker and General Chesney, do you have any plans to discontinue using physician assistants in your respective services?

Army

General BECKER. The Army is committed to continued utilization of physician assistants and has documented this decision in Army doctrine and force structure. These valuable members of the Army health care team are the most practical, cost effective and best suited health care asset for provision of first echelon medical care to active duty soldiers in maneuver units and the deployed setting. Army physician

assistants are also efficiently used as primary care in Army community hospitals. Most recently, the Army Medical Department has begun special training of a small number of experienced physician assistants for use in selected specialty clinics to maximize the efficiency of shortage physician specialists. Under current utilization policies, we project a requirement for 593 physician assistants through FY91 in the active Army. The physician assistant force requirement in the Reserve Components is projected to be 381 through FY91.

Air Force

General CHESNEY. Absolutely not. Physician assistants (PA's) saved our neck when we had a critical shortage of physicians. They have proven themselves as a vital part of our health care delivery team. PA's provide high quality care, are well accepted by patients, and are cost effective. We expect the number of PA's to remain about the same as is now authorized.

QUESTIONS SUBMITTED BY SENATOR SAM NUNN

PHYSICIAN ASSISTANTS

Senator NUNN. Admiral Seaton, could you explain how the Navy currently utilizes physician assistants?

Admiral SEATON. Physician assistants (PA's) are utilized as primary care physician extenders to facilitate our beneficiaries' access to the Navy health care system. As physician's extenders they: (1) obtain facts through history and physical examination; (2) order diagnostic x-ray and laboratory studies; (3) interpret findings and results; and (4) exercise a degree of decisionmaking judgment in treatment of diseases, disorders, and injuries. Physician assistants work under the direct supervision of a credentialed primary care physician.

Senator NUNN. Admiral Seaton, what was the rationale behind physician assistant's being trained and utilized in the Navy? Was it to meet a physician shortfall, or was it because physician assistants were deemed to be cost effective?

Admiral SEATON. Physician assistants were trained and utilized in the Navy to meet a physician shortfall.

Senator NUNN. Admiral Seaton, given the mobilization shortfalls in medical skills which we heard about last week, why have you decided to discontinue the Navy physician's assistant training program?

Admiral SEATON. We have a sufficient number of general medical officers to fill our authorized primary care mobilization billets.

Senator NUNN. Admiral Seaton, has the Navy looked into the possibility of using physician assistants in the field either in the Marine Corps or on ships by working with a physician or possibility in place of an independent duty corpsman?

Admiral SEATON. Physician assistants are used as physician extenders aboard aircraft carriers. They provide primary care under the direct supervision of a credentialed physician.

Senator NUNN. General Chesney and General Becker, how do you use physician assistants in your respective services?

Army

General BECKER. Physician Assistants (PAs) are qualified by academic and practical education to provide patient services under direct physician supervision. The PA may be physically separated from his physician supervisor but may not function independently. Each PA must be individually credentialed based upon an evaluation of his or her medical skills and training. Each PA should have the capabilities listed below:

Collect and record in proper format medical and social historical data appropriate to the patient's condition.

Perform a general physical examination. Record the findings in proper format and determine medical qualification for various purposes.

Select the most appropriate diagnosis in cases of uncomplicated common illnesses and injuries.

Recognize those more complicated cases and refer to a higher level of medical expertise for diagnosis and/or therapy.

Plan and initiate proper treatment within the scope and capabilities of the PA and facility.

Identify those situations and individual cases which have public health significance and carry out effective control measures.

Communicate to other health personnel orally or in writing in a clear manner the findings, diagnosis, and planned treatment regimen.

Conduct pertinent continuing education for assigned enlisted medics. Direct basic medical/sanitation training for nonmedical personnel.

Stabilize and manage a patient in a medical or surgical emergency and/or transfer to physician care.

Serve as primary medical staff officer in a maneuver battalion, if there is no assigned physician.

Determine appropriate means of evacuation of emergency patients, prepare patients for evacuation, and arrange for evacuation support.

The primary assignment for PAs is to combat maneuver battalions, troop medical clinics, and hospital ambulatory care clinics. Normal utilization should be for the delivery of primary, non-specialized outpatient care to all categories of patients. Specialized diagnostic and theraputic procedures may be undertaken after completion of properly documented training and experience. In addition to ambulatory care functions, the Army has trained a limited number of PAs in orthopedics and cardiopulmonary perfusion (heart-lung pump).

Air Force

General CHESNEY. In the Air Force, physician assistants (PAs) are commissioned as officers in the Biomedical Sciences Corps. PAs work under the administrative and professional direction, supervision, and review of physicians who are ultimately responsible for patients' care and well being. The majority of Air Force PAs are used in primary cases, acute care, family practice, and emergency services. Approximately 5% of the 473 PAs presently assigned are specialty trained in ear, nose and throat, orthopedics or surgery, and are used to assist physician specialists in those areas. In wartime, we expect to use Air Force PAs in second echelon facilities for definitive medical care. Specialty trained PAs, especially orthopedic and surgical PAs, will assist their physician specialist counterparts in caring for casualties. Air Force PAs must be graduates of the U.S. Air Force School of Health Care Sciences PA Training Course which is aproved and certified by the Suregon General, or graduates of American Medical Association Accredited civilian programs which grant baccalaureate degrees. Air Force PAs must be certified by the National Commission for Certification of Physician Assistants and credentialed by local credentials committees. Privileges are commensurate with each PA's education, training, maturity, and recommendations of the supervising physician.

QUESTIONS SUBMITTED BY SENATOR JEFF BINGAMAN

MISAWA HOSPITAL

Senator BINGAMAN. Dr. Mayer, I noted in Secretary Weinberger's speech last week, his remark that "Too often these overseas medical resources have been allowed to decay while large medical centers in the continental United States have flourished." He called for conserving our limited military construction resources for locations abroad where troops are deployed and alternatives are not available. Senator Sasser's staff has recently completed a report on military construction in the Pacific region and in that report they noted that the existing hospital at Misawa Air Base in Japan is "the most deficient military hospital structure ever toured by the minority staff. The hospital is housed in facilities which should have been torn down years ago. Few of the rooms are air-conditioned and the entire facility has the appearance of being held together by bailing wire." The report goes on to note that no hospital replacement project is scheduled until 1988 under the Japanese host nation support program and that funding in 1988 is by no means guaranteed. Are you going to have influence in the allocation of resources within the military construction programs funded at our request by host nations like Japan? My own staff visited this hospital in January and came away with an identical conclusion to that of Senator Sasser's staff and so I hope that you will be able to see that this replacement hospital is given higher priority within the Japanese Facilities Improvement Program.

Dr. MAYER. Health Affairs is familiar with the report prepared by Senator Sasser's staff and agrees that the situation at Misawa is deplorable. While Misawa is clearly the Air Force Surgeon General's highest priority for funding in the Far East, competition for scarce resources from the Japanese Facilities Improvement

Program (JFIP) will be increasingly intense. Starting with the fiscal year 1986 budget. OASD(HA) has been consulted on the prioritization of medical projects in Japan. We have fully supported the Misawa project and will continue to emphasize its importance. However, the extent of our influence in affecting JFIP prioritizations for allocation of resources is uncertain.

To respond to your concern that no hospital replacement project is scheduled at Misawa until 1988, I must point out that given the time required for design, 1988 is the earliest construction could be initiated, even if JFIP funds were available earlier.

PEACETIME MEDICAL ISSUES

Senator BINGAMAN. General Chesney, could you comment on the priority you would give replacement of the Misawa hospital and why the Air Force has not given it a higher priority?

General CHESNEY. Replacement of the USAF Hospital Misawa, Misawa Air Base Japan is one of my highest priority construction projects. The present hospital complex consists of 19 wood frame buildings, most of which are connected into a cantonment complex. These structures were built in the late 1940's and early 1950's. Our ability to practice modern medicine at Misawa AB is severely jeopardized by space constraints, building and functional inefficiencies and aging utility systems. This situation will worsen with the population increases associated with the new mission levied on Misawa AB. As a project eligible for the Japanese Facilities Improvement Program (JFIP), we began action to obtain Japanese funding in 1983. However, the Air Force Commando Port (F-16 beddown) initiatives have heavily taxed this funding source. We are encouraged that this project is submitted in the Japanese Fiscal Year (JFY) 86 for survey. Also, our project is now ranked number 9 on the Fifth Air Force prioritized list for funding of design in JFY 87 which conceivably could lead to construction funding in JFY 88. The Commander, US Forces Japan is responsible for the overall construction priorities in support of his mission and in so doing, strives to provide a balanced program within a limited budget. Our hospital project, recognized as urgently needed, competes with many other urgent projects. Its ranking of number 9 in the JFY 87 program attests to the high level of support the Air Force has given the project.

FORT DRUM MEDICAL CARE

Senator BINGAMAN. General Becker, could you tell us what the Army is planning to do to meet the health care needs of the service members and their families who will be stationed at Fort Drum, New York as part of the new light division being assigned there? Isn't this a medically under-served area in terms of ambulatory care? Are you planning to simply use CHAMPUS to cover these people's needs, or are you planning to contract out with local medical centers and to provide adequate ambulatory care at clinics on base? I am concerned that if adequate provision is not made for health care at Fort Drum, you are not going to find people lining up to be assigned there.

General BECKER. The Army has spent a great deal of energy and effort insuring that Fort Drum soldiers and families will have access to a first class health care system. The area is medically underserved for primary care but we are going to take care of that ourselves. We are assembling a comprehensive ambulatory care capability on Fort Drum proper, staffed with Army providers, augmented with contract specialists from the private sector. We already have contracts with specialists in orthopedics, pediatrics, ear, nose and throat, and gynecology. We will also assign enough family practitioners to empanel every married soldier and family in the family practice concept. CHAMPUS will be necessary but only for the low frequency specialties such as rheumatology where the workload would be too small to justify prospective staffing. This is the case at all installations. Beyond that, the on-post system will accommodate the vast majority of outpatient needs. We also have a sharing agreement with the VA medical center in Syracuse. This is a 369 bed teaching facility affiliated with Upstate Medical Center, Syracuse University and will provide an important augmentation to the on-post system for the more esoteric needs of selected patients.

There are three medical facilities in the fiscal year 1987 program for Fort Drum: a 38 chair dental clinic, an area troop medical clinic and an ambulatory care clinic. The ambulatory care clinic will also have minimal care beds and ambulatory surgery capability to take maximum advantage of same-day surgery practices.

The Army is not planning a hospital for Fort Drum. Health planners from my office and the U.S. Army Health Services Command have worked closely with local

health care authorities and other state and federal agencies to insure the health requirements of the Army are well understood. The excess bed capacity presently existing in hospitals adjacent to Fort Drum is sufficient to meet the projected needs of Army patients through division maturity and beyond. Consequently, since the costs to the patient of an inpatient episode are essentially the same as they would be in a military facility, the Army intends to utilize local hospitals rather than build.

Fort Drum will be the first large Army installation without a military hospital and the concept of using civilian hospitals to provide inpatient services of this magnitude will present new and exciting challenges and opportunities as the division builds.

LARGER OUTPATIENT WORKLOAD

Senator BINGAMAN. Dr. Mayer, in May the General Accounting Office produced a report titled "Implementing Outpatient Surgery Programs in Military Hospitals Can Reduce DOD's Health Care Costs." The conclusion of that report was, as the title indicates, that outpatient surgery programs should be enlarged so as to avoid inpatient costs in DOD facilities and in CHAMPUS. What are you doing to try to implement GAO's recommendations in this regard? In our society as a whole at the moment there appears to be a trend towards decreased utilization of inpatient facilities and greater utilization of outpatient facilities. How are you trying to deal with that trend within the DOD health care system?

Dr. MAYER. The Department of Defense supports the GAO's recommendations and we are currently taking steps to implement those recommendations. First, we are developing a DOD-wide policy to encourage outpatient surgery programs in military hospitals. This policy will include a list of surgical procedures suitable for performance on an outpatient basis. Second, we are developing a methodology to determine at which hospitals it is cost beneficial to implement outpatient surgery programs. At these facilities where it is cost beneficial to implement outpatient surgery programs, we will direct the Military Departments to do so. In addition, we are designing all new facilities under construction to accommodate outpatient surgery programs.

NON-SMOKER'S PREFERENCE UNDER CHAMPUS

Senator BINGAMAN. Dr. Mayer, is any thought being given to a non-smoker's preference under the CHAMPUS program? For example, we could have a lower deductible for non-smokers and a higher deductible for smokers than at present so that the cost would come out the same as at present.

Dr. MAYER. As part of a comprehensive reassessment of our peacetime health care benefits and how they are delivered and paid for, we will be considering how a variety of disease prevention and health promotion features, including rewards for not smoking, might be effectively incorporated in the total system, including CHAMPUS and any improved alternatives to CHAMPUS that are developed.

COMPREHENSIVE REVIEW OF CHAMPUS BENEFITS

Senator BINGAMAN. Dr. Mayer, earlier this year I met with Teresa Hawkes, the Director of CHAMPUS, and asked her about ways to improve the CHAMPUS benefit program. I had in mind improved coverage for some preventative procedures such as innoculations and certain diagnostic tests such as PAP smears. There also seems to be a need for improved coverage of catastrophic illnesses under CHAMPUS. Ms. Hawkes told me that CHAMPUS was planning to carry out a comprehensive review of its benefits. The review was going to draw on the experiences of private health care providers who in recent years have tested a variety of benefit programs and cost-sharing methods. Will this review be ready in time for the next budget cycle up here in the Congress? Should we be expecting a legislative proposal next spring for changes in coverage under the CHAMPUS program?

Dr. MAYER. We have underway a comprehensive reevaluation of the entire Military Health Services System with particular attention to its benefits and how they are delivered, managed and paid for in the context of varied beneficiary needs and the most effective, affordable ways of meeting them. We are considering the many proven and innovative methods used in the competitive private health care system environment. Included in this broader reassessment is a review of CHAMPUS benefits as described to you by Ms. Hawkes, including specific attention to preventive measures and the early detection of health problems. Our goal is to develop at least initial proposals for forwarding to the Congress next year but given the broad scope of the process that is underway, a more precise schedule cannot be determined at this time.

ATTRACTING PHYSICIANS WITH SURGICAL SPECIALTIES TO THE RESERVES

Senator BINGAMAN. Dr. Mayer, the information that we have is that there is a serious shortage of physicians with surgical specialities in the active duty forces. Since the peacetime military medical system only has so much demand for these specialties, we clearly are going to have to meet much of our requirement through the reserves. What actions are being taken or what initiatives are being planned to make the reserves more attractive to physicians with surgical specialities? Do you think that shorter enlistment periods for surgeons in these specialities in the reserves would work in your favor or work against you?

Dr. MAYER. Great emphasis and conscientious efforts have been placed on the procurement and retention of surgeons and surgical support personnel in the Reserve components. Starting in 1983, my office initiated a series of programs designed to enhance reserve service by increasing the amount of flexibility given the physician in scheduling and completing training requirements. Also, programs encouraging overseas training opportunities (usually popular with our medical officers) and service-sponsored participation in graduate medical education were instituted. In general, the services have complied with these initiatives and a steady increase in surgical personnel available in the Reserve system can be demonstrated.

Recently at our request, the DOD Inspector General completed an audit of Reserve Component Medical Manpower which made excellent recommendations to improve manpower management and flexible training options which I am restating in directive form and sending to the Services. The services themselves have greatly intensified recruiting efforts with sharp focus on critical skill shortages. Recently we have seen proposed dollar incentives both in the form of draft legislation and proposed programs developed by the Services. We are improving, but we must continue to press for concentrated efforts in recruitment and retention while exploring every possible incentive and policy that can further enhance the successes that have been experienced. No small factor has been the continued display of interest and concern by the Congress.

Although some unit commanders and recruiters protested the increase in the minimum statutory obligation from six to eight years as being counterproductive to procurement, there was no perceptable change in the increasing rate of accessions. Since Reserve Component service is voluntary, the participant determines the amount of time he or she wishes to commit by selecting the level of participation from the demanding unit schedule to the relatively lesser demands of the Individual Ready Reserve. Physicians shift from one level of participation to another and back again as their available time and interests change. It does not appear that a change in the length of service contract or minimum service obligation is needed at this time.

USE OF SULFITES ON MILITARY INSTALLATIONS

Senator BINGAMAN. Is the use of sulfites wide-spread in the food service divisions of the various services?

Dr. MAYER. According to the Chairman, DOD Food Planning Board within the Office of the Assistant Secretary of Defense (Acquisitions and Logistics), an anti-oxident (sulfite) powder is used by the Armed Services in their military dining facilities to maintain crispness of vegetables and fruits and to help prevent browning of these products. Last year, 13,096 pounds of anti-oxident powder was issued to the services by the Defense Personnel Support Center, which centrally purchases subsistence items for our troop feeding program. The majority of these issues were to the Army and the Navy. This item is authorized for local purchase by each military installation. However, data are not available as to how much of this product has been purchased locally at the installation level.

Senator BINGAMAN. Do you agree that this does pose a potential hazard to military personnel and their dependents?

Dr. MAYER. Sulfites are widely used as a preservative in our country. Military personnel and their family members obtain food from the same sources as our civilian counterparts. A January 1985 publication from the Federation of the American Society for Experimental Biology (FASEB) lists twelve pages of foods that contain sulfites. Whenever our military personnel or family members eat out in restaurants, there is a very high potential that they consume sulfites. Early in 1984 the Food and Drug Administration asked FASEB to re-examine the generally recognized as safe status of sulfiting agents. FASEB established a panel which considered all relevant information on sulfiting agents. The final panel report became available on January 31, 1985. The Panel concluded, in part, that available information contained sufficient evidence to demonstrate a hazard of unpredictable severity to sul-

fite-sensitive individuals when they are exposed to sulfiting agents in some foods at levels that are now being used. It found that, in some cases, sulfite-sensitive individuals have had life-threatening responses following exposure to sulfite-treated foods. Based on the Panel's findings, FDA proposed in Federal Register, Volume 50, No. 157, Wednesday, August 14, 1985 to revoke sulfiting agents' generally recognized as safe status for use on fruits and vegetables intended to be served or sold raw to consumers. My staff has discussed this proposed rule with FDA and it is anticipated that the amended FDA regulations will be published in early 1986. The use of sulfiting agents in DOD food service facilities and retail distribution points has been discussed by the DOD Health Council in October 1984 and in February 1985. Initiatives to discontinue the use of sulfiting agents were discussed. The Council agreed that informing food consumers of the presence and potential dangers of these compounds would be prudent. Additional actions were deferred pending the release of a report on the subject by the Food and Drug Administration.

FDA has informed my staff that it has had 20 deaths reported. Out of 14 deaths reviewed by FDA, there is a strong possibility that 8 deaths are associated with sulfite consumption. One of these 8 persons was a dependent wife. I believe that sulfites are a potential hazard for our society as a whole and not just military personnel and their dependents.

Senator BINGAMAN. And is the Department of Defense planning to take any actions to curb the use of sulfites as a preservative agent in foods?

Dr. MAYER. The Armed Forces Product Evaluation Committee (AFPEC), a permanent committee of the DOD Food Planning Board which determines the food items authorized for military use, has recently coded anti-oxident compounds for termination from the DOD supply system. Anti-oxident compounds containing sulfites will be replaced with non-sulfite compounds that have been identified by the DOD's food research and development agency, the U.S. Army Natick Research and Development Center (NRDC), as being effective and available in the commercial marketplace. This action will be completed in the near future. In the meantime, many of our military dining facilities have voluntarily stopped using sulfite compounds. All services have provided consumer information on potential health hazards related to the use of sulfiting compounds.

USE OF SULFITES

Senator BINGAMAN. General Becker, do you have anything you would like to add concerning this sulfite issue and your Service's policy toward the use of sulfites?

General BECKER. The Army Surgeon General's office is aware that the Food and Drug Administration (FDA) has recently proposed to ban the use of sulfiting agents on fresh fruits and vegetables. Actions are underway to greatly reduce the use of sulfiting agents and to seek alternative compounds for use in military subsistence. We will continue to seek and follow the guidance of FDA to assure the wholesomeness of the food supply for military personnel.

Senator BINGAMAN. Is the use of sulfites wide-spread in the food service divisions of the various services?

General CHESNEY. Air Force policy published in AFR 161-26, Control of Foodborne Illnesses, permits conditional use of sulfiting agents on fruits and vegetables that will be eaten raw providing the consumer is notified by a warning sign. This policy is consistent with FDA policy which limits the amount of sulfiting agent used, provides warning to the consumer, and permits use of these agents on fresh fruits and vegetables for sale/service in the raw state.

The U.S. Army Natick Research and Development Center is working to develop a fruit and vegetable freshner without sulfiting agents.

All processed food specifications are reviewed by the Air Force Engineering and Services Center personnel and sulfiting agents are deleted when possible.

Senator BINGAMAN. Admiral Seaton, do you have anything you would like to add concerning this sulfite issue and your service's policy toward the use of sulfites?

Admiral SEATON. In April of this year the Navy Medical Department launched a Navy-wide consumer education program on potential health hazards related to the use of sulfiting agents. The package included general information on sulfites from the Food and Drug Administration (FDA) as well as recent educational material published jointly by the National Restaurant Association and the American College of Allergists. Medical practitioners were advised to discuss the problem of sulfite-containing foods with patients who are asthmatic or sulfite-sensitive. This general information was sent to all Navy food service program managers and educators, and to all Navy medical facilities.

Many Navy food service facilities have voluntarily eliminated the use of sulfites in food preparation. Formal direction regarding further changes will be undertaken upon finalization of new FDA guidelines regarding use of sulfites.

Senator WILSON. This hearing is adjourned.

[Whereupon, at 12:33 p.m., the subcommittee adjourned, to reconvene upon the call of the Chair.]

MILITARY MEDICAL CARE SYSTEM

TUESDAY, OCTOBER 8, 1985

U.S. SENATE,
SUBCOMMITTEE ON MANPOWER AND PERSONNEL,
COMMITTEE ON ARMED SERVICES,
Washington, DC.

The subcommittee met in open session, pursuant to notice, at 10:32 a.m., in room SR-232A, Russell Senate Office Building, Senator Pete Wilson (chairman) presiding.

Present: Senators Wilson, Nunn, Kennedy, and Glenn.

Staff present: Patrick A. Tucker, counsel; George K. Johnson, Jr., and David S. Lyles, professional staff members; Patricia L. Watson, research assistant and Mary J. Kampo, staff assistant.

Also present: Mark J. Albrecht, assistant to Senator Wilson, Allan W. Cameron and Deforest Hamilton, assistants to Senator Denton: Jeffrey B. Subko, assistant to Senator Exon; Gregory B. Craig, assistant to Senator Kennedy; and Phillip P. Upschulte, assistant to Senator Glenn.

OPENING STATEMENT BY SENATOR PETE WILSON, CHAIRMAN

Senator WILSON. Good morning, ladies and gentlemen. I welcome you here for this third in the series of oversight hearings being conducted by the Manpower and Personnel Subcommittee on the military medical system.

In our earlier hearings on this subject, we have heard from administration witnesses about the status of wartime medical readiness and about the efforts in the Department of Defense to ensure quality, and reduce the cost, of peacetime military medical care.

I think that the testimony that we have heard so far can be categorized as follows:

We are not prepared to provide the medical care which would be needed in the event of a major armed conflict. Medical readiness was badly neglected throughout the 1970's and, while major strides have been made in the past 5 years, we still have a long way to go if we are to make our military medical system capable of performing its primary wartime mission.

This will be especially difficult in an atmosphere in which more and more is demanded from the Defense Department while at the same time it is demanded that the defense budget be reduced.

The peacetime situation is much more complex. The military medical system is being asked to provide full medical care to more than 10 million people. We are asking that from a system which was not designed to furnish this type of care to such a beneficiary population.

The quality of care being furnished in the peacetime environment is of major concern to everyone involved in the system, beneficiaries, providers, and leaders of that system. The Assistant Secretary of Defense for Health Affairs and the Surgeons General are working hard to improve the quality of care in the military system. But the task is enormous, and there are no easy answers.

Finally, improving our wartime medical readiness does not necessarily enhance our peacetime capabilities; and conversely, improving the system's capabilities to ensure that it provides the highest quality of care available in a peacetime situation has little bearing and may do little to ease our requirements of our wartime demands.

I can make this fairly critical summary of our previous testimony because the administration witnesses have been very candid with us during the last two hearings. I again thank them for their testimony and candor, and even more for the very clearly apparent attitudes they have displayed to give us medical quality assurance of a kind that the system has lacked heretofor.

The time has come now to hear from a number of witnesses from outside the system, outside the administration, those with critical views whose views arise, obviously, from a different perspective.

We are very pleased this morning to have as our first witness The Honorable Jim Sasser, the senior Senator from Tennessee. Senator Sasser, along with Senator Kennedy and others, is an original sponsor of S. 489, a bill which would modify the *Feres* doctrine as it applies to military medical care.

While the bill is not pending in this committee and is the property of the Judiciary Committee, nonetheless, we are entertaining Senator Sasser's testimony and more broadly, an inquiry that revolves around the *Feres* doctrine as it relates to the question of midical quality assurance because that is the concern of this subcommittee of the Senate Armed Services Committee.

While the bill is not before us, it does address that matter of serious concern to us and I expect we will be discussing the issue this morning with Senator Sasser in the context of quality assurance.

Because of this interest, I have also invited Dr. Mayer, the Assistant Secretary of Defense for Health Affairs and Mr. Robert Gilliat, the Assistant General Counsel of the Department of Defense for Manpower and Health Affairs to appear briefly after Senator Sasser to give us the opportunity to question them about the *Feres* doctrine and those alternatives to Senator Sasser's legislation that they feel may provide more effective medical quality assurance.

We will next hear from a panel of three witnesses composed of Dr. Janet O'Brien, the director of research for the National Association of Military Families, and then from Mrs. Mary Day, vice president of the Citizens Against Military Injustice and chairwoman of health affairs for that organization.

Then from Dr. Stanley Skillicorn, director of medical affairs of San Jose Hospital in San Jose, CA, who has written extensively and is regarded as one of the real pioneers in the area of quality assurance in the American medical system.

We have a lot of ground to cover this morning. I ask that each of the witnesses orally summarize their written statements. Let me

assure you that your written statements will be inserted in the record in their entirety.

Additionally, in order to afford an opportunity for those witnesses whom we do not have time to hear this morning, we are allowing them to enter written statements and to afford them the opportunity, we will keep the record open.

We will ask that in order that those who are attending this morning, and we are expecting other Senators to be in attendance, that we operate under the 10-minute rule.

Let me repeat that I have received requests from several organizations to be permitted to submit statements for the record at this hearing and to accommodate their requests, the record will be kept open until the close of business on October 15 to receive their statements.

We are expecting Senator Glenn who has not yet arrived, but I will invite the distinguished ranking member of the full committee, Senator Nunn, who is past chairman of this subcommittee and who has a keen personal interest in the subject of manpower and particularly health care, indeed it was both through the interest of the subcommittee itself and at the expressed request of Senator Nunn that we have held these three hearings and, in fact, it appears to the Chair that there may be need for additional hearings.

With that, I invite Senator Nunn's statement. Then we will hear from Senator Sasser as the first witness.

Senator Nunn?

Senator NUNN. Thank you very much, Mr. Chairman.

Again I want to thank you for having these hearings. I think they are enormously important. I believe that you have already gathered a great deal of enlightened testimony for the Members of Congress by holding these hearings.

I think the fact we are holding these hearings and attention has been focused on these problems will inevitably result in possible improvements.

I am delighted to be here. Unfortunately, I have to be on the floor with Senator Goldwater on a full committee matter. I will be leaving here in 15 minutes. I will have my staff here and they will be equally informed. I will be back as fast as I possibly can.

Senator WILSON. I welcome Senator Sasser here. He is an outstanding member of the Appropriations Committee. He is the ranking member on the Senate Appropriations Military Construction Subcommittee. That subcommittee of the Appropriations Committee has enormous influence here.

Senator Sasser, we welcome you and we are delighted to hear from you this morning.

Senator SASSER. Thank you.

Senator WILSON. Senator Sasser?

STATEMENT OF HON. JAMES R. SASSER, A U.S. SENATOR FROM THE STATE OF TENNESSEE

Senator SASSER. Mr. Chairman and Senator Nunn, I want to commend this committee and the chairman for holding hearings on the health care system of our military services and also, Mr. Chairman, I want to thank you and the distinguished members of this

subcommittee for giving me the opportunity to present my views this morning.

I became concerned about the quality of military medicine a few years ago as a result of case work bubbling up from my State which revealed that a number of Tennesseans in the military services had received substandard medical care at military facilities.

Some of these cases, I might add, Mr. Chairman, have become quite celebrated and received quite a bit of notoriety in the past few months. One in particular was the case of a young Navy petty officer by the name of Doyle Stanley who ultimately had his forehead removed and he has no bone covering the frontal portion of his brain now.

Mr. Chairman, before I go any further, I would like to call the attention of the subcommittee to the fact that legislation to allow active duty personnel to sue the military for medical malpractice passed the House of Representatives last evening. It passed overwhelmingly by a vote of 317 to 90 and I think this sends a clear message that the time has come to change a 35-year-old court imposed law.

I would hope that this legislation will now receive favorable consideration here in the Senate. I look forward to working with this subcommittee and its distinguished members in implementing this important piece of legislation that will grant our military people full justice.

Let me say that as a result of investigating the case work that came into my offices in Tennessee, I became convinced that these cases clearly involved negligence and I initiated a review of military medical practices to determine if the problem cases were isolated or part of an overall deficiency in the military medical system.

Unfortunately, my investigation confirmed the worst suspicions, my worst suspicions, that these individual horror stories that had been brought to me were not isolated instances.

Programming rules and regulations existed on paper in military medicine, but were often ignored. Complaints I found of poor quality care were met with indifference by many health personnel in the military services.

Audit reports recently released by the Department of Defense inspector general's office have subsequently confirmed that problems do exist in military health care. I am encouraged by the concern that the Department of Defense itself is showing for these problems, encouraged by some of the reforms they are presently initiating.

The reports that DOD released and the results of my investigation and the results of the General Accounting Office investigations reveal that:

No. 1, the services did not have an adequate quality assurance program.

No. 2, that rules and regulations, while in place, including the standards on accrediting of hospitals, these rules and regulations were not followed.

No. 3, physicians' credential files were not kept constant and did not contain proper documentation.

No. 4, that credentialing of physicians in the military service was lax. The audits showed that nearly 75 percent of all the physicians practicing military medicine did not have current credentials.

No. 5, that medical records for many patients were out of date, were incomplete, particularly in the emergency rooms.

Some observers have criticized the recent publicity which has been given to the crisis in military medicine. These observers believe that such publicity may serve to undermine the confidence of service members and their families in the military medical system.

It is my experience, however, that our military personnel and their dependents have long been aware of the deficiencies which exist in military medicine. Public debate does not undermine the military medicine delivery system. The deficiencies in the system itself undermine the confidence of those it is supposed to serve.

In making these comments, I do not mean to imply a blanket indictment of military medicine. As each of you knows, there are many highly qualified, and hard working, extremely competent medical professionals stationed on military bases throughout the world. These individuals deserve our support, commendation, and our praise.

These competent and dedicated professionals provide quality medical care to millions of patients. But their efforts and their reputations are being undermined by a system that permits negligence and malpractice by a minority of military practitioners.

I believe that recent public exposure of some of the deficiencies in military medical systems has assisted in focusing public and congressional attention on the need to reform the military medical system, and has already worked to strengthen the credibility of that system.

As I said earlier, I am greatly encouraged by the positive steps that the Department of Defense has been taking in the last several months to improve its medical quality assurance programs. New directives on credentials and on requiring licenses are steps in the right direction and should be applauded.

The establishment of a peer review organization to study the quality of care, particularly in cases resulting in death, is a step that is long overdue. These programs should help to provide our military people with a standard pattern of data on care.

We see a positive movement. But there is much left to be done.

Mr. Chairman, a Department of Defense survey indicates that users of military medical facilities believe they will receive better care at civilian facilities than at DOD facilities. Many of those using DOD medical facilities feel they are powerless to complain about the care they receive. It was in response to concerns of this sort that I introduced legislation to change the *Feres* doctrine.

Currently, the *Feres* doctrine bars suits by active duty service members for medical malpractice, as we all know. The *Feres* doctrine serves as a symbol of a military medicine system that is often unresponsive to those who use it.

I believe that fairness and equity demand that service men and women have during times of peace, the same rights and privileges as those Americans who are treated in civilian medical facilities. Those rights, in my view, include the right to sue for damages,

money damages, when inferior medical care is delivered. My legislation would permit such lawsuits.

My legislation to repeal the *Feres* doctrine is opposed by the Department of Defense and the Department of Justice and is, therefore, not likely to receive speedy consideration by the Judiciary Committee.

I do hope, however, that this legislation will help accelerate the consideration of reforms and new procedures to strengthen the military medical system and reduce the incidents of poor quality care.

Mr. Chairman, I would like to address briefly the issue of wartime readiness. The Secretary of Defense and the Assistant Secretary for Health Affairs, Dr. Mayer, have recently spoken out on the need to improve our wartime medical readiness and I applaud their statements.

Certainly, the Secretary is correct in his view that the primary mission of military medicine is the care of wartime casualties. The fact is, however, that this Nation would currently be unable to provide timely medical care for many of our wartime casualties. Correcting that deficiency must be afforded a high priority by the Department of Defense and by the Congress.

One critical deficiency, in my view, is the lack of sufficient prepositioned wartime contingency medical facilities in Europe and the Far East. The Department has requested $32 million for five such facilities in South Korea, Guam, the United Kingdom, Spain, and Turkey to help correct this deficiency.

Unfortunately, the House Committee recently cut these projects from the fiscal year 1986 Military Construction Appropriations bill. As the ranking minority member of the Senate Subcommittee on Military Construction, I am supporting the restoration of these funds when my subcommittee marks up in the next few days.

Congressonal support for these medical contingency warehouses is a vital element in improving our wartime readiness.

Present plans call for the pre-positioning of 232 such wartime hospitals by 1990. Implementing that plan is going to be costly. $2 billion is estimated, but history has proven over and over again that nations unable to care for their wounded in wartime are unable to sustain their armies on the battlefield.

We cannot allow the United States to be medically unprepared for war. We must address these readiness issues as a major priority.

During my review of these medical contingency projects, however, I have come to appreciate other issues which point to the need for the separate military services to cooperate better and enter into joint planning and delivery of medical services.

For instance, in Korea, there is a critical need for the proposed Air Force medical contingency complex bugeted for $10 million in fiscal year 1986. However, the Air Force proposes to locate this facility at Kimhae, which is also the location of a maintenance facility which would be critical to sustaining aircraft in a prolonged war in Korea.

Such a site would most certainly be a target of an enemy seeking to reduce the U.S. ability to sustain operations in the Korean theater. This fact raises questions with regard to the sufficiency of the

Air Force's planning process for such facilities close to what would be a military target.

In addition, the Air Force initially planned this facility without consulting the Army in Korea to ascertain if joint use or location of contingency facilities was feasible or desirable.

I am pleased to report to this committee that such discussions are now underway, and I believe the Congress may want to require that contingency planning efforts be coordinated by the three military departments to ensure that, in the future, such facilities are planned efficiently and with the maximum joint use.

Mr. Chairman, I believe that most of us would agree with Secretary Weinberger's view that wartime medical readiness should be the top priority of military medicine. However, the quest to improve wartime readiness must not result in the further deterioration of medical delivery to service members and dependents in peacetime.

A number of suggestions have been made to establish a new health care policy which would permit military patients to be treated by civilian doctors at civilian hospitals or perhaps to be treated by health maintenance organizations. Tests are being conducted to ascertain the value of such arrangements.

I am not prepared today to endorse any of these proposals. I believe more details are needed before such reforms are recommended by the Congress. It may well be true that the very austere Federal budget will not permit a military health care system dedicated to both wartime and peacetime missions.

However, we should make it clear to the Department of Defense that the Congress will not tolerate policy changes designed to improve wartime readiness at the expense of the quality of life of our peacetime forces.

Mr. Chairman, the "Navy Times" recently published an editorial which points out many of the questions which are unresolved as the Pentagon begins to emphasize wartime readiness enhancements. I commend this editorial to the members of the committee and ask unanimous consent to include it at this point in my testimony.

[The editorial follows:]

[From the Navy Times, Sept. 30, 1985]

MEDICAL PRIORITIES

It is difficult to fault Defense Secretary Caspar Weinberger and his health affairs deputy, William E. Mayer, for whatever steps they take to enhance the readiness of the military medical system and smash interservice rivalries that drive up costs. Without question, the system's top priority must be to provide timely and thorough care to U.S. service members, particularly in a wartime emergency.

Toward this end, Weinberger and Mayer announced plans September 16 for a major restructuring of military medical staffs and resources to eliminate gross deficiencies they see in the services' ability to care for wounded during wartime. For too long, they said, the health care system has been overburdened with both peacetime and wartime missions.

Pentagon officials have warned for years that during a major conflict only a fraction of U.S. casualties would get the care they need because of shortages in equipment, material, surgeons and other staff specialties. But we also are told that because of bigger defense budgets the readiness gap is closing. Where it once was claimed that only one of every 10 wounded would be properly cared for during wartime, the proportion more recently has climbed to four of every 10. This gap is expected to disappear by 1992, if Congress provides the funds required.

The news then from Weinberger and Mayer is not that readiness problems exist but what they now plan to do about it. The "restructuring" includes a dramatic shift in priorities for service hospitals and clinics away from family-oriented care for dependents and retirees and toward a more combat ready system. "I see no need," Weinberger said, "to perpetuate any system that produces an oversupply of physicians whose specialties are not relevant for our fighting forces in their time of greatest need."

Despite the commendable objective of their plan, Weinberger and Mayer cannot expect the military community to embrace it willingly without hearing more on the costs and benefits. The plan as now sketched is unsettling for both military health care beneficiaries and for medical staffs.

Weinberger and Mayer have given assurances that turning dependents from service hospitals toward civilian facilities will result in them having better access and continuity of care with no increase in costs. How this is possible without driving service medical budgets to unacceptable heights is not clear. Only two years ago, DOD ordered military hospitals to crack down on the number of nonavailibility statements issued to beneficiaries allowing them to seek care under CHAMPUS from civilian doctors and hospitals. DoD wanted to rein in costs for the military's insurance program by sending more dependents and retirees to military hospitals.

Weinberger and Mayer now want to move in the opposite direction. To improve medical readiness, they say, dependents will have to get their care primarily from the civilian sector. Yet they have not explained how this can be achieved without strapping beneficiaries with higher out-of-pocket costs. The military so far only has experimented with substitute programs for CHAMPUS such as health maintenance organizations and government contracted outpatient clinics. While there is optimism, it's no certainty that these alternates can provide a full range of care to dependents and retirees at minimum cost.

Among medical staffs, a more important question is—What's to become of those in the system who provide general medical care, such as obstetrics and pediatrics. Are their career paths now blocked? And how challenging, from a medical standpoint, will military service be if, as one veteran surgeon worries, physicians have to "sit around the firehouse waiting for the alarm to sound."

These concerns will come into sharper focus and perhaps be resolved as defense leaders try to convince the military community and Congress that they have a better idea.

Senator SASSER. Mr. Chairman, I would conclude by expressing the view that our service people and their dependents must not become second-class citizens. Quality medical care for members of the military services and their families should be one of the secure benefits provided to an All-Volunteer Armed Force.

I look forward to working with members of this committee to help develop appropriate steps to improve the quality of military health care delivery.

Again, I applaud this subcommittee for holding these hearings on a very, very vital topic.

Thank you.

Senator WILSON. Thank you, Senator Sasser.

We all applaud your assistance on quality care and the actions you have taken to encourage it.

Senator NUNN. Mr. Chairman, may I place in the record a report prepared by one of Senator Bumpers constituents which he forwarded to me and has some very thought-provoking suggestions here?

I would like to insert this in the record at this point.

Senator WILSON. By all means.

[The report follows:]

U.S. SENATE,
COMMITTEE ON APPROPRIATIONS,
Washington, DC, October 7, 1985.

Hon. SAM NUNN,
U.S. Senate, Washington, DC.

DEAR SAM: As part of its 1982-83 reorganization of its medical department, the Navy eliminated its dental division as a separate entity. A constituent of mine, a Naval Reserve dentist, has written the enclosed brief report on the negative consequences this has had on the Naval dental care delivery system.

The concerns raised by this report are troubling and indicate a need to review the Navy's action. I hope you will review this report and use it in your hearings this week on the health care delivery system of our armed forces.

If you or your staff have any questions on this issue, please contact either me or Bruce MacDonald of my staff at 224-4843. Many thanks.

Sincerely,

DALE BUMPERS.

Enclosure.

THE NAVY DENTAL CORPS AND REORGANIZATION—1982-83

SUMMARY

After the debates of the 1930's and the experiences of World War II, it would have been unthinkable in 1946 to have consolidated naval aviation with the surface navy. Both uniquely indispensable to the overall mission of the Navy but their effectivness would have been compromised if not assigned to billets related to their training, experience and background.

The Navy Medical Department experience of that same era gave rise to the legislation in 1945 that created the Dental Division for specific reasons. Namely, that the Navy Medical Department consisted of two uniquely different health care delivery systems—medical care and dental care. Both are important to the Navy mission but each requiring different training and experience to be effective.

Today the crisis for reorganization has moderated and a more constructive atmosphere exists among the major players in the reorganization drama. Hopefully we have learned quickly the areas in which the reorganization structure has beget efficiency, quality and more effective control of the medical care delivery system.

Reorganization is a vehicle, not an objective.

Reorganizations are successful only to the extent that they can be objectively used, studied, modified, revised, retracted, reworked and refined to perfection.

Reorganization designers are usually guilty of paternal protection. They often are guilty of redoubling their efforts to protect their sacred cow against the mighty hoards of infidels, after they have lost sight of their original objective.

During every major American mobilization in this century, dental health problems have been a major factor, if not the major factor, in lost time and nonavailability of personnel. We cannot afford the luxury of further weakening the most productive, cost effective, efficient dental care delivery system in the history of military medicine.

At the earliest possible date the Dental Division command and control of the Navy dental care delivery system, as required by law, must be re-established, either in fact or in principle, taking fully into account compatable ways in which the Dental Division personnel can complement the reoganized Navy Medical Department.

Navy medical care and Navy dental care are compatable, synergestic services but they are not made up of interchangeable parts. In order to flourish and prosper, they must be free of each other's dominance and control. They came in different boxes and have different instructions.

By trial and error and by capitalizing on their own uniqueness, each can find its own best route to excellence.

"If it ain't broke don't fix it!"—(Murphy's Law)

INTRODUCTION

The Dental Division of the Navy Bureau of Medicine and Surgery was established by law in 1945. For 36 years the chain of command of the Dental Division was considered the ultimate military concept for insuring the delivery of high quality dental care in an efficient and responsive manner. The Navy Dental Division concept was both envied and emulated by dental corps of the other military services.

The Navy Medical Department was reorganized in 1982-83. During the early planning of the reorganization, the format for the administration of Navy dental health care was in accordance with the Act of 28 December, 1945, 10 U.S.C. 5138. For reasons never discussed or made public, the Dental Division was eliminated. Today, the chain of command of the dental care delivery system is fragmented to the point of being ineffective. Dental responsibilities are dispersed within the reorganized Navy Medical Department creating chaotic management and benign neglect of the dental care delivery system.

The law assigning Dental Division responsibilites has not been changed, only circumvented.

The liaison between the Dental Division and the Naval Reserve Dental Corps has been eliminated.

The superb Navy dental care delivery system was not broke but it is being fixed ————?

BACKGROUND

Following the establishment of the Navy Dental Division Corps in 1912, the Secretary of the Navy in June of 1946, established the Dental Division within the Navy Bureau of Medicine and Surgery in compliance with the Act of 28 December, 1945, as codified in 10 U.S.C. 5138.

Since June of 1946, all matters relating to dentistry are required by law to be referred to the Dental Division and that division is responsible for the study, planning, and direction of all matters coming within its cognizance. Specifically, the Dental Division is required by law to:

(A) Establish professional standards and maintenance of such standards;

(B) Conduct inspections and visits for maintenance of such standards;

(C) Initiate and recommend actions pertaining to complements, appointments, advancement and training of dental personnel.

The Chief of the Dental Division is responsible to the Surgeon General for the supervision, direction and coordination of the Navy Dental Corps and all associated programs. He is responsible for continual appraisal of all programs over which cognizance has been assigned and is responsible for all the functions of the Dental Division.

The above description of the Dental Division command and control authority has allowed the Navy Dental Corps to control its own destiny since 1946 under the guidance of the Surgeon General. During the 36 years from 1946 until late 1982, the Dental Division of the Bureau of Medicine and Surgery served the Navy and Marine Corps with conspicuous distinction. The Navy Dental Corps established a bench mark of excellence, efficiency, responsiveness, and esprit de corps unequaled by the Dental Corps of the other military services.

The Navy concept of command and control within the Dental Division was adopted by the Army in 1978 to improve their efficiency of operation, simplify their chain of command and make their dental care delivery system more responsive to field commands.

REORGANIZATION

In the late 1970's and early 1980's the Navy prepared for the reorganization of the Bureau of Medicine and Surgery. No serious consideration was given to changing the Navy's dental care delivery system in early reorganization studies. A 1979 study of the Navy Bureau of Medicine and Surgery by CRESAP, McCORMACK and PAGENT contained the following:

"Fundamental differences in mission, treatment methods, and resource stringency exist between the medical and dental arms of BUMED."

"Consolidation of dental and medical regional centers into a single command structure is unlikely to integrate the Dental Corps more fully into the Medical Department and could well have an opposite effect."

"This would severely restrict opportunities for promotion and the assumption of command by dentists, while requiring physician/commanders (nurse/commanders and medical service/commanders) to assume responsibility for the oversight of clinical activities with which they are unfamiliar. It could also have an adverse effect on the presently high esprit de corps of Navy dentists. . . ."

"Senior medical officers interviewed expressed particular concern that consolidation of dental services under medical regions would divert the attention of regional commanders from more pressing responsibilities."

"Although in theory some administrative duties could be absorbed by counterpart medical personnel, recent practical experience indicates otherwise."

"Complete regional consolidation risks resource reallocation at the local level without central policy direction . . . an environment of direct competition for funds between medical and dental activities could be created (and) that the results would be a shift of resources from dental to medical activities."

"A shift of resources from dental to medical services could mean a shift from dental care of active-duty personnel to medical care for unmet needs primarily of dependents of retired personnel."

(A copy of Chapter III (DENTAL) of the study of BUMED is attached.)

Following a Command Inspection of the Headquarters, Chief Bureau of Medicine and Surgery the Navy Inspector General recommended that the Bureau of Medicine and Surgery be disestablished and that geographic third echelon commands be established for regional medical and regional dental commands. He further recommended, because of their uniqueness, that National Naval Medical Center and National Naval Dental Center remain as third echelon commands. This recommendation would reduce the number of Medical Department third echelon commands from 57 to 18, which he described as a "manageable span of control".

The reorganization of the Navy Medical Department was authorized by memorandum order by Under Secretary of the Navy James F. Goodrich on 21 September, 1982 and has not been codified by law to date. The reorganization was designed to:

(A) Replace the Bureau of Medicine and Surgery with two organizations.

Echelon I (Plans & Policy), Director of Navy Medicine/Navy Surgeon General.

Echelon II (Operations), Navy Medical Command.

(B) Narrow the span of control of the Surgeon General from the existing 57 commands to a more manageable number by establishing:

Echelon III, Geographic Navy Medical Commands.

(C) Correct problems that existed in the medical care delivery system. Most specifically, but not limited to, the impending loss of accreditation of Bethesda Naval Hospital.

(D) Improve the combat readiness of the Navy Medical Department.

At the time the memorandum order authorizing the reorganization of the Navy Medical Department, no significant problems existed in the Navy Dental Division. Given the historic performance of the Navy dental care delivery system and the following findings by CRESAP, McCORMACK AND PAGENT it is inconceivable that the Navy Dental Division was allowed to be massacred during reorganization.

". . . most line commanders interviewed during the course of the study expressed favorable views about both the quality and the availability of BUMED's dental service. Dental services were often described in terms such as 'excellent' and 'outstanding'."

". . . dental regions have also been able to deploy resources in ways that very effectively respond to the needs of the operational forces of the Navy and the Marine Corps.

"Dental regional esprit de corps and aggressive response to unique line needs were also cited as positive features of BUMED dental support."

"Line officers generally perceive personnel in dental regions as more career oriented and more focused on military needs than personnel in medical regions."

An early draft of the reorganization Echelon I staff (Director of Navy Medicine/Navy Surgeon General) listed a "Deputy Director of Navy Dentistry (OP 093D)" reporting to the Surgeon General with staff members for Dental Policy (OP 093D1) and for Dental Programs (OP 093D2). A revised draft on 8 November, 1982 listed "Navy Dentistry" as a Special Assistant reporting to the Deputy Director of Navy Medicine. This demotion prompted the following comment in a memorandum from the Assistant Commandant of the Marine Corps to the Vice Chief of Naval Operations.

"Although not directly a Marine Corps matter, I felt obligated to voice concern over the placement of the Chief of Dentistry within the proposed structure. In my opinion, there are two functional services offered by the Director of Naval Medicine: medical care and dentistry. Although complementary health services, they have historically been treated with some degree of separateness in identity. The proposed relegation of the office of the present Chief of Dentistry to that of a "Special Assistant for Dentistry" may cause perceptional problems which may provoke significant and unnecessary morale problems within the Dental Corps. I urge you to reconsider the case for a Deputy Director of Navy Dentistry."

The Deputy Director of Navy Dentistry was not restored. The most recent organizational chart (1 June, 1985) of the echelon I staff (Director of Navy Medicine/Navy Surgeon General) listed the "Chief of the Dental Corps" reporting to the Surgeon General with no staff for Plans or Programs; no chain of command authority over the dental aspects of the Resource Division, Plans and Programs Division, Health

Care Operations Division or the Education and Training Division; and no command and control authority over the Navy dental care delivery system. The Dental Division, established by law, is conspicuously absent.

The echelon II staff (Operations) of the Navy Medical Command does not contain a dental operations section. The various operation sections of the Dental Division have been dispersed into other directorates not under the command and control of the Chief of the Dental Corps.

The systematic excision of the Dental Division concept of command and control of the Navy dental delivery system is without portfolio and does not comply with the act of 1945 either in fact or in principle.

OPERATIONAL PROBLEMS

Today, after 30 months of operating the dental care delivery system in the reorganization mode, major problems are developing due to fragmented command authorty and chaotic management.

(1) The Chief of the Dental Corps does not have the chain of command authority to supervise, direct, and coordinate the activities of the Navy Dental Corps and all associated programs as directed by law. The Navy dental care delivery system is too large and complex to be handled by fragmented command and control.

(2) The Chief of the Dental Corps does not have a dental staff or chain or command authority over existing staff personnel to perform the duties assigned by law to the Chief of the Dental Corps.

(3) Chief of the Dental Corps is currently an additional duty/part time job. Supervision, direction and coordination of the activities of the Navy Dental Corps and all associated programs, as directed by law, cannot be done as an additional duty. The Dental Corps with its history of excellence must not become the victim of benign neglect.

(4) Units of the Fleet and Fleet Marine Force receive dental care and dental support from the Navy Medical Command (Echelon II). Not only does the Chief of the Dental Corps not have a direct chain of command to provide guidance and coordination for these fleet programs, the Navy Medical Command, likewise, had no dental line of authority through which it can coordinate and monitor the Navy dental care delivery system to these vital programs.

(5) Decisions affecting the dental care delivery system are being made by Medical Corps, Nurse Corps, and Medical Service Corps officers who have little or no background, training or experience in dentistry.

Dental Corps officers, likewise are assigned to jobs requiring decisions affecting the medical care delivery system with which they are usually unfamiliar.

Because of the small number of Dental Corps officers dispersed throughout Echelon I, II and III staff positions, most decisions affecting the dental care delivery system are being made in the unnecessary and unrealistic absence of dental expertise.

Prior to reorganization, Dental decisions were made by senior Dental Corps officers on the Dental Division Staff and under the guidance of the Chief of the Dental Corps and the Surgeon General.

(6) Morale is becoming a problem with senior Dental Corps officers who have aspired to higher dental command. Regional dental commands have been renamed "dental clinics" and their commanding officers report to a Geographic Commander (Echelon III) who usually is not a Dental Corps officer.

Most dental officers do not look forward to assignments outside their professional or specialty areas. No dental command opportunities exist above the dental clinic level; only Medical Department commands

Many dental officers find themselves under the command of other Medical Department officers who have no understanding of the dental care delivery system and its importance to overall Navy readiness. Early retirement is, for many senior dental officers, their best option if they prefer working within their profession.

(7) Competition for dollars and manpower appeared very soon after reorganization: Competition for operating funds, contingency funds, training funds, post graduate education funds, research and development funds, facilities, and equipment.

Budget matters, worked out between the Chief of the Dental Corps and the Surgeon General prior to reorganization, are now matters of debate and discussion at the division level of echelon I, at the directorate level of echelon II, and the assistant chief of staff level of echelon III.

Because of the small number of Dental Corps officers assigned to these commands, the dental care delivery system often loses by default to the interest of the

Medical Corps, Nurse Corps and Medical Service Corps officers of the medical care delivery system.

(8) The close coordination between regular and reserve Dental Corps officers had consistently made the reserve dental programs among the most effective in the entire Navy.

This liaison and close coordination has been eliminated in favor of one Medical Service Corps officer attempting to coordinate all Medical Department reserve programs.

Given the massive problem of developing and coordinating the reserve manning programs for fleet hospitals and hospital ships as only one example, it is unlikely that Navy reserve dental programs will get adequate attention.

Elimination of such a key element in the success of the reserve dental programs raises questions about the depth of reorganization analysis to date.

Coordinating the Navy Reserve dental programs is a Dental Corps program and will only be done adequately when it is again the responsibility of the Navy Dental Corps.

Senator WILSON. Senator Glenn?

Senator GLENN. Thank you. Mr. Chairman.

I have an opening statement I will enter into the record. I am sorry I could not be here at the opening.

I know from other conversations with Senator Sasser of his very profound and personal interest in this matter. We have talked about it a number of times over on the floor of the Senate where we sit side by side, so I know of his personal interest in this.

I will certainly read all of his testimony here. We all want to work on it together.

Thank you very much.

[The prepared statement of Senator Glenn follows:]

PREPARED STATEMENT OF SENATOR JOHN GLENN

Mr. Chairman, I want to join you in welcoming our colleague, Senator Sasser, and our other witnesses this morning.

Our two previous hearings have focused on shortcomings in our wartime medical readiness posture and our peacetime medical capabilities. Today we have the benefit of civilian health care professionals and beneficiaries of the military health care system.

During this morning's hearing we will again be focussing on Peacetime Military Medical Care, but from a somewhat different perspective. We welcome back Dr. Mayer and Mr. Gilliat and appreciate the time they have shared with us in our investigation of the military medical system. We are also welcoming several other witnesses who will be providing their impressions of the military medical system. I am quite interested in hearing their views on quality assurance, the *Feres* doctrine, and what the military members and their families feel the strengths and weaknesses of the present system are.

As we continue to closely examine the entire military health care delivery system we must continue to focus on whether the deficiencies can be corrected within that system or whether fundamental changes will be necessary.

Mr. Chairman, I look forward to the witnesses' testimony. I will have questions later in the hearing.

Senator WILSON. Thank you, Senator Glenn.

Senator Sasser, your very thoughtful testimony brings out a number of questions.

QUALITY OF CARE

First, I think it is clear that you have several objectives in introducing your legislation, but the paramount concern expressed by you is the improvement of medical care, the quality of that care.

I think perhaps we ought to focus on that, that is the proper concern of this subcommittee as opposed to what we will say is also deserving of congressional attention and that is the adequacy of

compensation for the recipient of medical care that results in injury.

It is your thought that your legislation will achieve both of those things, both the improvement in medical care and a more adequate system of compensation?

Senator SASSER. Yes; Mr. Chairman, I do feel that way about it. I think that a repeal of the *Feres* doctrine would allow, of course, active duty military personnel to bring suit in a court of law.

This would not only allow a jury of their peers in that community to pass on what money damages they might be entitled to, but I think, more importantly, it would focus the white light on public attention on any inadequacies that may exist in the military medical system.

We have seen, for example, in some areas where dependents have brought suit in a court of law. This has had the effect of focusing public attention on one particular military hospital that I do recall where a number of outrageous malpractice incidents had occurred.

I think if we can expand this and allow active duty personnel to sue, this would have the same impact. It is a question, I think, of focusing public attention on the problem and also if a suit is brought in a court of law, I think that would focus attention on the military physician or others in the military medical system who might be the ones who perpetrated the malpractice. It would aid in singling them out, so to speak.

Senator WILSON. I don't know whether time will permit you to remain and I doubt that it will, as busy as we all are. It may be that you will not be here when Mr. Gilliat submits his testimony. I don't know if you have had a chance to read his testimony, but he spends a great part of his time really challenging that basic assumption that underlies the legislation.

In other words, agreeing with you on the necessity to secure needed reforms and, incidentally, I think your own efforts, those of others, those by the Department, as you have pointed out in your own testimony, already have brought about some needed changes.

His testimony challenges the assumption that the best way to achieve medical care is through the kind of accountability which presumably in your legislation would attach as a result of the repeal of the *Feres* doctrine.

He can speak more eloquently for himself, but for the purpose of putting my question to you, I think what he is saying is that leaving aside the question of compensation, and we can get to that, but directing it specifically to quality medical care assurance, the trouble with the repeal of the *Feres* doctrine is that it does not attach the kind of liability to the individual practitioner in the military that it does in civilian life.

If I am guilty of medical malpractice, then as a civilian practitioner, it will cost me or, more accurately, my carrier, my insurance company. That is not the case with respect to military malpractice.

If a judgment were entered into in that instance, it would be against the United States and it would be the taxpayer who pays the bill. That is not to say that those of whom we ask the sacrifice to serve their country, a privilege it may be, but it entails a sacri-

fice, that they should not have the same rights to adequate compensation for military medical malpractice.

The real question, though, is if we were to assume, and I am not assuming it for the present, but if for the sake of argument, we assume adequacy of compensation for the present disability, the question is how do we go about achieving the kind of necessary reform that will give to you and to me and the parents of young servicemen and women the assurance that we desire, that their children will be receiving quality medical care. How will those who are providing the leadership over that means of monitoring and holding accountable the individual practitioner within the military medical establishment, offer a better chance of that than simply affording a damages remedy against the U.S. taxpayer.

Senator SASSER. Mr. Chairman, I don't say that the repeal of the *Feres* doctrine is a panacea, that that is going to guarantee quality care in the military medical system. I don't think any reasonable proponent of this legislation would say that.

But I do say that if a military physician is sued for malpractice and a judgment is rendered against him or her, even though they don't pay the judgment as civilian physicians do not pay it, they are covered by malpractice insurance, the judgment attaches to their reputation.

For example, the Navy physican who erroneously gave a medication to a constituent of mine with a heart condition which killed him, if he had read the medical records, he would have known that that medication was contraindicated for an individual with this heart condition.

If he had been sued and a judgment rendered against him, then that would have attached to his reputation in the military medical system. I assume there would have been an entry in his fitness report that a judgment had been rendered against him in a court of law in money damages.

When that naval physician came up for promotion, I expect that would have appeared in this fitness report and he might not have gotten that promotion.

So, I say simply because they do not pay the judgment does not mean that the finding of fact in a court of law that they did indeed commit malpractice does not attach to their reputation, I would submit, Mr. Chairman.

In regard to this particular case I am talking about where my constituent was given a medication which killed him, his family—his wife and three children—were unable to sue for money damages in a court of law and get money damages for his wrongful death. And as a result, they receive a small percentage of the salary that this petty officer was paid while he was living and in the Navy, and they were hardly able to survive on his salary, full salary, while he was working.

Now they are out trying to survive on 20 or 30 percent of his salary.

I suppose the answer to the other testimony would be that we are trying to correct an injustice with this legislation, but even more than that, if there is a finding of fact in a court of law that a physician has indeed been negligent, then I will say that attaches

to that physician's reputation and will be with him in the military, or otherwise.

Senator WILSON. Senator Sasser, on that point, if the purpose of the legislation is to hold the physician individually accountable in a way that will exact from him a performance of presumably a higher standard than what might otherwise occur, then an alternative procedure that achieves the same result I assume would accomplish the purpose.

I am not arguing at the present time for the adequacy of the disability system. In fact, I think it contains inadequacies. If we did nothing else, this subcommittee at least has jurisdiction and a responsibility to examine the adequacy of that system.

If the Judiciary Committee, which has jurisdiction of your bill at the present moment, were to determine that in order to achieve the kind of accountability that you seek in your proposed repeal of the *Feres* doctrine and were to suggest that a procedure to monitor and hold individually accountable the attending physician were in order as opposed to a collateral action for money damages to parallel civilian remedy, that might afford the same desirable result, which is to say that someone who is guilty of medical malpractice will be held to account for it, his reputation will be made to suffer and his career would be made to suffer, his promotions likely denied.

What I am obviously trying to do, since we don't have the bill, but since we have the responsibility for the quality of the medical care, is to focus on two different objectives of your legislation and merely ask hypothetical questions based on the fact that we may see, an amendment on the floor before we see the committee taking action, before the Judiciary Committee takes action.

To the extent possible, I want to try to make a record for the entire Senate.

Senator SASSER. Thank you, Mr. Chairman.

I am pleased to see one of the senior members of the Judiciary Committee here today. He is one of the cosponsors of my legislation. I am hopeful that he will use his influence to move this legislation out of the Judiciary Committee as soon as possible.

Senator KENNEDY. Mr. Chairman, I apologize to the witness, my good friend from Tennessee, for not being here for his presentation. I was in another hearing. I want to commend him for his initiative, and I would like to ask that my opening statement be included at this point in the record.

[The prepared statement of Senator Kennedy follows:]

PREPARED STATEMENT BY SENATOR EDWARD M. KENNEDY

Mr. Chairman: When it comes to the question of quality of life for men and women in our military services, there is no more important question than the quality of health care and medical treatment available to military personnel and their dependents.

In my view, the question of military medicine and health care includes not only questions of competence and adequate treatment but also questions of availability. For that reason, I want to commend the efforts made by the Army in its pilot project—recently launched—called PRIMUS which provides readily available primary care to military personnel and their dependents in the Fort Belvoir catchment area. This is a positive development, and the results of PRIMUS will be important to follow.

But the topic of the hearings today is the difficult and painful issue of medical malpractice.

I want to welcome Senator Sasser today. He has raised the important issue of whether the *Feres* doctrine should continue to bar active-duty service personnel from recovery from the United States for injury caused by medical negligence by military medical personnel. There are obviously important considerations on both sides of this issue—but I think it is important that we keep in mind one fact: the issue of the *Feres* doctrine is only one element in the larger question of how we go about insuring that our military personnel have high quality medical treatment available to them.

And I just want to say that, whatever differences we may have with the services or with the Department on the issue of the *Feres* doctrine, it is important that we continue to work together to make certain that quality assurance programs go forward—such as the peer review system that Secretary Mayer recently established—so that, whatever legal remedies may be available when malpractice occurs, the incidence of malpractice can be sharply reduced.

Senator KENNEDY. Mr. Chairman, I want to express again my appreciation to you for these hearings that we have had on the quality of medical care for the military personnel. I think it has been one of the most important set of hearings that we have had in the Armed Services Committee. It has been an area which we have not focused on.

In my travels to various military bases, I have a very keen sense, as I know the chairman and my good friend from Ohio has, about the priority that the military places on quality health care and the ready availability of quality health care.

This is a matter of uniform importance, and I think the Senator from Tennessee has made an extremely strong and compeling case in his presentation here. I look forward to working with him in the Judiciary Committee to see if we cannot get some action.

I am sure the Senator is aware of the action taken in the House yesterday. Did you make reference to that earlier?

Senator SASSER. I made reference to that in my opening statement.

Senator KENNEDY. I would hope we can get some similar action.

I thank the Chair and I thank the Senator from Tennessee.

Senator WISLON. Senator, do you wish to make some response on that point about the two ways to skin this cat?

Then I understand you have a time problem, Senator Glenn.

Senator GLENN. Yes. I have a couple of questions.

Senator SASSER. Mr. Chairman, I am not sure I completely understand the question, but let me say any way that we can guarantee or assure quality health care for the members of our military services, I will be very supportive of any effort to do that.

If there are other ways to do it, you can count on my support.

Senator WILSON. Thank you.

Senator Glenn?

Senator GLENN. Thank you, Mr. Chairman.

Just a couple questions here.

I note we are mainly talking abut the *Feres* doctrine, and so on, being able to sue. There is another aspect of this also and, of course, that is if we get to the lawsuit phase, the system has failed, somebody has been hurt badly or they wouldn't go to court over it.

I don't want to get this hearing far afield here, but I wonder if you have looked into this any further as to how we get good people

in, keep them in, and how we provide good facilities which is one of the things you addressed in your statement.

I don't know if you have gone into this in detail or not.

I am also concerned, as we have addressed it at other hearings here, about how we get the finest physicians in, how we make sure they are fully qualified, and then how we provide them the best facilities to provide the military care that is necessary.

It seems to me those are a couple of things we should be focusing on also. I want to see us correct the system so that we have very few lawsuits, hopefully.

Would you care to address that or have you looked into it?

Senator SASSER. Let me say to my distinguished friend from Ohio I think that improvements in the military medical systems are probably being made.

I think they are being made partly as a result of a focus of public attention on the inadequacies of the system and also because of an awareness that has built up in the Department of Defense itself that there are indeed problems in the military medical system that they are now starting to move to address.

How you attract the best physicians in the military, I am not sure that I can answer that question. We did construct a military medical school a few years ago. I understand that the quality of physicians that are emerging—I think there are one or two classes that may have graduated now—the quality of those physicians is excellent, I am told.

Perhaps we should give some consideration to raising salaries of military physicians, but perhaps even more importantly we should give some consideration to not moving personnel in the military medicine field the way we move other military personnel.

That is, allow them to remain on one station for a longer period of time, allow them to have some say-so perhaps about where they are to be stationed and that sort of thing. That might make military medicine more attractive or make it easier for us to keep some of those who are presently in military medicine.

I am not sure, Senator Glenn, that the problem is always the quality of the physician that we are dealing with. Many times it is just the system, I think, that causes problems, and system in which records aren't kept properly, a system in which a patient, for example, is entrusted with his or her medical records, not knowing the importance of them, carrying them from place to place, losing parts of the record, and that sort of thing.

It is a complex problem and it is going to take a complex answer. I think we are moving in the proper direction now and I think the passage of this legislation will accelerate that movement.

Senator GLENN. I don't disagree with any of that.

I was noticing an article in the Washington Post this morning about the House passing the military lawsuit bill, as they called it, yesterday. I would read out of one paragraph.

"The Pentagon and the Reagan administration strongly oppose the bill, contending, in part, that suits by active duty military personnel could undermine military discipline and unduly involve civil courts in a review of military decisions."

That struck me as rather an odd opposition to this thing.

Would you care to comment on that?

Senator SASSER. Well, it struck me as rather odd. That is what has been said time after time by some of our people in the Pentagon, it would undermine discipline.

Of course, dependents have the right to sue now. If the wife of a sergeant in the Marine Corps sues for malpractice and she gets a judgment, that does not appear to undermine discipline in the Marine Corps.

I do not see what difference it would make if the sergeant, himself, sued rather than the wife.

Senator GLENN. My view is exactly the opposite. My view is military discipline will be enhanced, that military morale is going to be enhanced.

It is not going to undermine military discipline to know that we have the best medical system to back them up and if all fails, you have the same right as anyone else to make sure that your family is protected by law against malpractice.

If that is the rationality and it was correctly stated by Margaret Shapiro who wrote this particular article, if that was accurately reported, I disagree with the Pentagon and the administration very strongly that it will undermine military discipline.

It may undermine military discipline among some of the few doctors, I can understand that, but not military discipline across the board in the Defense Department, certainly not.

It is going to be the other tack on that. It is going to be an increase of morale and not lacking military discipline. It is not going to undermine it. It is going to enhance it, as I see it.

You mentioned stationing of people at places for longer periods of time. That is a thing in the military that goes across the board. No one likes to move. They used to move every 2 years. I never made a move that I liked at that time, with few exceptions, I guess.

To take a certain group of people and say they are beyond transfer or they have to stay someplace, that means other undesirable military posts, you are going to have a fellow assigned out there that did not want anything anywhere. At the worst duty post you get the worst doctor along with it if you follow your rationale to its legal conclusion.

I am not sure I would go along with you on the stationing of people at their request because everybody may want Walter Reed and Bethesda and the farther away from the urban centers you get, the less medical expertise you might get if you follow that rationale on through.

One thing that has been done to get good people, the new regulations go into effect within 3 years, is that there will be a licensing procedure required. Doctors previously could come out of medical school, go through residency and go into service with no further checks, no requirement to pass a medical board test.

At least that is a step in the right direction. Credentialing goes along with that as a way of judging whether the medical person, he or she is adequate, but I want to work with you on this.

I appreciate your testimony before the committee.

Senator SASSER. Thank you very much.

Senator KENNEDY. May I ask one question, Mr. Chairman?

Senator WILSON. You may ask more than one, Senator Kennedy. It is your turn.

Senator KENNEDY. One of the other objections that is raised is the disparity in the State laws and the inconsistency that would develop with various causes of action.

Do you want to address that question?

Senator SASSER. I will say to my friend from Massachusetts that the suits, as I understand it, would be subject to the provisions in the Federal Tort Claims Act and presently under that particular system any suit against the Federal Government is subject somewhat to the laws of the jurisdiction in which the suit is brought.

Also dependents of military personnel who can now sue for malpractice do so and those suits are brought under the law in the jurisdiction in which the tort arises.

So, I think that is also a fallacious argument that can be quickly laid to rest.

Senator KENNEDY. We have people, obviously, in the 50 States who live with different laws. That is the current situation for all our citizens in terms of recovery and how their rights are going to be protected.

So, the fact that there are different bases in different States and that the existing State laws differ is really an extension of the fact that people live in different jurisdictions.

I do not think people probably travel to different parts of the country in order to be able to live in a particular community to take advantage of some State law on medical malpractice.

Senator SASSER. I would say that is correct.

Senator KENNEDY. That seems to me as well to be an argument that is frequently made, but without justification.

I thank the Chair.

The other matters were covered by the earlier questions.

I want to thank the witness.

Senator WILSON. Thank you, Senator Kennedy.

Before we excuse Senator Sasser with our very big thanks for his appearance this morning and the keen interest he has taken in this problem, since your legislation does seek to avail itself and provide to prospective plaintiffs the remedies and procedures of the Federal Tort Claims Act which does refer in turn, as Senator Kennedy has brought up, to the substantive tort liability law of individual States where the situs of injury occurred. Is it also true under the Federal Tort Claims Act that a plaintiff or prospective plaintiff injured outside the United States is not afforded a remedy?

Senator SASSER. Mr. Chairman, I have not practiced law for about 8 years. Frankly, I do not know. I am not sure I know when I practiced law. I cannot answer that question.

Maybe there are some learned lawyers in this audience who can.

Senator WILSON. Senator Sasser, I do not know why we should expect you to be current on every specialty in law. If you are, you are 1 in about 10 million.

Thank you very much.

Senator KENNEDY. Before you leave, would you comment about the existing recovery availability at the present time?

I suppose there will be a point where there is a possibility of full recovery?

Senator SASSER. I think, Senator Kennedy, it is clearly inadequate. I cited a moment ago one of the cases that brought this

whole problem to my attention was a case of a petty officer in the Navy who had a heart condition. He was treated, I think at Portsmouth Naval Hospital, as I recall, and they gave him a drug that was contraindicated to his heart condition and it killed him.

His wife and children were seeking to recover some sort of money damages. An attorney contacted me and asked if I could help him. Obviously, we could not.

As I recall, the award that they were given by the board that heard their claim was something like 25 percent of the petty officer's salary or something like that, clearly inadequate.

So, I would say the present system is just inadequate, the claim system that is in place now.

Senator KENNEDY. Thank you.

Senator WILSON. Thank you very much, Senator Sasser. We are very grateful to you for being here this morning.

Senator SASSER. Thank you.

Senator WILSON. Next we will invite Dr. Mayer and Mr. Gilliat to the witness table.

Dr. Mayer, welcome back. We apologize for taking as much of your time as the subcommittee currently is doing, except for the fact I think you agree with me that the problems that we are addressing warrant that effort and even the very generous contributing of your own time that you have made.

STATEMENT OF HON. WILLIAM MAYER, M.D. ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

Dr. MAYER. Thank you, Mr. Chairman and Senator Kennedy.

First of all, I want to express again my very sincere gratitude to the members of this committee for the interest they have shown, both in our medical readiness problems and the problems of maintaining quality of care.

I am particularly grateful to Senator Nunn for having initiated these hearings sometime ago with Senator Goldwater. I believe this gives us an opportunity to lay before you and before the public that we serve what it is that we are actually doing, the kinds of problems we face and our proposed solutions to them.

I am very grateful actually to Senator Sasser for the kinds of support that he has given us, particularly in connection with the medical readiness issues and the military construction overseas.

I must respectfully take issue, however, with his position with respect to lawsuits directed to the physicians in the Armed Forces. It is my seriously considered judgment, with all due respect to the great majority in the House of Representatives who voted for this bill, it is still my serious belief that permitting active duty personnel to sue their physicians will not have any significant effect one way or the other on the quality of health care that we deliver.

This is not to say that there may not be very serious problems of equitable compensation and other legalistic problems, which is why Mr. Gilliat is here to address them.

But, as was pointed out already, the great majority, or about three-fourths of all our patients today, are perfectly free to sue the providers of military health care and they do so.

The rate at which they do so is far less, less than half actually, of the going rate of malpractice actions that are brought in the civilian community.

As far as the reference to the cost to the doctor, it is true that most physicians must carry medical liability insurance and those in the Armed Forces do not. So, it is that the liability insurance company pays the bill, the doctor suffers a certain diminution of his professional reputation.

I would like to point out, however, that in the Armed Forces the doctor is in no way screened when an action is brought against the Government for alleged malpractice. In a recent case without even going to court, two senior officers who were involved in a way that was not directly connected with patient care, but involved in the sense that they did not respond in a way that that military department felt they should, these officers have suffered the almost total loss of their medical credibility, they have left the service, their financial penalties, individually, covered by no insurance, amounts to about $500,000 in effect changing the course of their lives.

They are in very serious trouble. So, it is not that the physicians today on active duty in the Armed Forces are somewhat exempt and can in some cavalier fashion treat patients without regard for the consequences. The consequences can be and in some cases are very severe.

I have pointed out that our physicians are much less frequently accused of any kind of medical malfeasance by those who are free to do so than our colleagues in the civilian community.

I do not mean to imply that there is not room for improvement in the quality of military health care, not at all. We do not deny, cannot, the tragic cases that have received public attention. They in fact occur as they do in every medical system and while they do occur in our system as others, I must strongly object to the notion that somehow these cases characterize military medicine, that overall it is of substandard quality.

It is clearly not, judged by the number of suits filed against us.

We are making major changes in our delivery system and we are doing everything that we believe is humanly possible with the current state of the art in medicine in quality assurance measures to try absolutely to prevent such sad occurrences in the future.

However, permitting our military uniformed beneficiaries to bring suit for alleged malpractice would not contribute materially, in my judgment, to the more positive efforts that are already taking place. It would not result in improved health care in the military health care system any more than the threat of suit has improved health care in the civilian medical system.

The threat today, the malpractice situation, is considered virtually out of control and a major crisis in American medicine.

The avenues that we in the Department of Defense are pursuing to improve the quality of our system are of a different nature. Our efforts are designed to directly impact on the way health care is delivered, on the credentials of each and every person that provides that care, and on how the care is evaluated.

I should parenthetically say that Senator Sasser's reference to findings by auditing bodies and the inspector general in the Armed Forces to the fact that there were defects in our system; that those

reports which we ourselves initiated and cause to take place showed that there were defects in the process, in no way suggested or declared that there were defects in the care actually given.

Also, those surveys were done nearly 2 years ago and we have corrected each and every point that our inspectors general and our auditors have brought up.

Our new standards and procedures have been implemented. Before they were very new, many of them were not formally implemented in the way we wished. They are being implemented now according to the regulations and the directives which we have published and we are continuing to ask for help and look for new and innovative ways to improve the quality of care.

The cases that we all know about are truly heartbreaking cases and no one can make an excuse for them. We can only remain determined as a result of them to change the system in whatever way will improve it.

Once again, finally, I would like to emphasize my very strong belief that simply by allowing an additional 25 percent of our patients to sue for malpractice will not have any significant impact one way or the other on quality.

I cannot visualize a physician or any other health care professional treating two patients with similar disorders in two different ways simply because one can sue him and the other cannot sue him.

It saddens me to think that anyone truly believes that the quality of medicine can only be improved by instilling fear of the consequences on the part of the physician. If fear were the principal motivating factor in maintaining quality of care, then the state of American medicine is tragic.

Thank you very much.

PROCEDURES TO ENSURE ACCOUNTABILITY

Senator WILSON. Thank you, Dr. Mayer.

Before we entertain testimony from Mr. Gilliat, let me ask you a question.

You feel strongly your obligation in medicine, both military and civilian, to provide quality care. I am struck by the conviction with which you expressed your attitude.

Let me just ask you this. You feel that Senator Sasser's proposal is not the answer, and I suspect that there is something in your response that bespeaks a pride and a conviction in your profession that is offended by that approach, and I agree if fear were the sole motivation that impels physicians to take pains for the adequate care of their patients, we would indeed be in a tragic situation.

Obviously, these problems have arisen because you are unhappily not the uniform rule, there are exceptions to that, your testimony has made note of them.

The question, then, really is, if we are not to achieve accountability by repeal of the *Feres* doctrine and a system of accountability that attaches personal liability to the offending physician, then by what other system are we going to achieve that accountability and what you and I and the parents of young servicemen and women really want which is prevention?

There is not anyone, I am convinced, who does not find a wrongful death action or even damages for a surviving crippled recipient of bad medical care very cold comfort. That is not the answer.

What we are seeking is prevention by the actions of adequate care.

Specifically what I would ask is whether or not there is in any single procedure now employed by the Department of Defense or within any of the individual services, a means whereby a claim can be brought against an individual physician, charging improper care to active duty personnel? Is there a system in which a claim of that kind, a charge of that kind, is actually investigated and the results of the investigation recorded?

Dr. MAYER. Yes, indeed, there is, Senator.

First of all, I would like to say that in no sense do I advocate any lessening of the accountability not only of the treating physician, but of those who supervise him and command him, and in fact in certain respects I believe that the accountability process in the Armed Forces is a much more stringent one than on the outside. If a physician in our system is accused of gross negligence of some act in connection with his duties, and it is determined to be clearly wrong, overtly careless or culpably negligent, then that physician is not monetarily penalized by the system that is in place, but what he is subjected to is the Uniform Code of Military Justice, the discipline of his superiors which is very clearly prescribed throughout the code and his behavior is prescribed, not down to the details of what he does as a physician, but what he does as an officer and as an agent of the United States.

As I said, in the recent case that you are all familiar with, not only is the physician involved being held accountable, but his superiors have already been held accountable and have been punished for their failure to function in a more decisive way.

All I am arguing is that the physician is not exempt from public attention, from the light of publicity. If a charge is made that a physician has done a wrongful act, he will be required to appear in court just as he is in civilian court.

The consequences to him and to his entire career and his entire economic future are very severe.

PROCEDURES TO REGISTER COMPLAINTS

Senator WILSON. If it comes to light, as it has in some of the more celebrated cases, that is clearly the case, that is not my question.

My question is: What procedure affords the individual soldier, sailor, airman, marine an opportunity to register this complaint?

Now, UCMJ does so in only an indirect fashion. I am a private and if I feel I am aggrieved, I can go to my platoon commander and he in turn can take things up, if he is persuaded of my case, to the battalion commander, on up the chain of command and ultimately it may result in the filing of some charges under UCMJ.

I think to say that is relatively rare is an understatement.

Dr. MAYER. I would not abandon all confidence in the chain of command.

Senator WILSON. I do not, but I do not think that there is a prescribed procedure. If there is, I am not aware of it beyond the fact that if there is a gregarious error that comes to light in some other fashion, then presumably it would travel up the chain of command.

Dr. MAYER. Even without having to go through the chain of command, our inspector general system makes it possible for the lowest private to register any complaint, legitimate or not, with respect to the quality of his health care and, of course, with respect to many other aspects of care.

But, specifically, a patient in uniform in a military hospital, no matter how low his state, can go immediately and with absolute confidence and confidentiality to the inspector general and lay before that person, who is detached and uninvolved judge of the situation, his case and it will be looked at.

The IG cannot ignore such requests and such complaints. In fact, many of the things we have found out that we have taken measures to correct have been as a direct result of our learning through that system or through the system of command.

Senator WILSON. Let me go through a case. It gets to the IG. What does the IG do with it? I am the IG. I am the deputy base commander and I am inspector general. Maybe I have had some legal training, maybe I have not. Presumably I have had no medical training.

What do I do with this charge?

Dr. MAYER. If you, in your judgment, consider it is a meritorious charge, first of all, you would seek medical advice to make sure you were not making judgments beyond your area of expertise.

If on the basis of your consultation with qualified experts, you felt that the private had a legitimate problem that he was complaining about and this was supported by independent medical judgment that you are free to obtain and is readily available, then it would behoove you as the inspector general to report that matter directly to the commanding officer, not just the person in charge of the ward, but the commander, and this would become a matter of official record, it could not be ignored by the commander.

He would then have to make a determination based on what the IG says, whether a formal judicial inquiry should be made and the process would follow itself to its course. It is not a difficult process. It is a much easier one than is available to John Doe, citizen in a community hospital who has a complaint.

He can go to the hospital administrator, I suppose, which will not guarantee anything. He is forced ultimately to go to his attorney. The attorney then has to initiate at considerable cost, unless he has a contingency, whatever investigations he thinks are necessary. It is a very cumbersome thing.

It is very difficult for the average citizen to put into effect even though a great many people do it these days.

For the soldier who is well aware that there is an inspector general system in each branch of the service that is very carefully protected from command influence, that is operated independently, he knows he can call on the IG and he must be heard and heard by a dispassionate observer.

I think the system really provides the individual with far more protection than is generally available in the community.

Senator WILSON. The procedure that you are describing is one that operates within a framework of confidentiality?

Dr. MAYER. Yes, sir, absolutely.

Senator WILSON. Confidentiality. This is a question that has both medical and also other implications. The question I would ask is whether or not that confidentiality, which as its beneficial aspects, may not suffer in the lack of publicity that it gives?

Dr. MAYER. If the Inspector General——

Senator WILSON. Mr. Gilliat, I am going to let you answer these, too. It looks like you are itching to respond.

Dr. MAYER. Could I answer just that last comment?

Senator WILSON. Yes.

Dr. MAYER. The confidentiality of the situation protects the individual who makes the complaint, that is true. It may prevent publicity from being shown in some instances, but certainly if the IG finds that there is something that needs to be done, he makes a formal report to the commander.

At that point the plaintiff, if you will, no longer is sheathed in secrecy. At that point he becomes a participant in a case in which the command and the judicial people are going to be involved.

So, it does not keep the case secret. It only keeps it secret long enough to make sure that the soldier does not suffer from having had the temerity to make his complaint.

I think the inspector general system is working very well indeed.

Senator WILSON. Could you furnish for the record the total number of complaints that have been provided through the IG system on a service-by-service basis over the last 5 years?

Dr. MAYER. I am sure it is possible to get that information, sir, and I will make sure you get it.

Senator WILSON. I am talking about medical practice.

[The information follows:]

MEDICAL MALPRACTICE CASES PROCESSED THROUGH INSPECTOR GENERAL'S (IG) OFFICE

Since April of 1981, when the IG's data base came into existence, this office has processed 22 cases of alleged malpractice. Of these, 8 were related to the Army, 7 the Air Force, 6 to the Navy and 1 was cross-service.

PHYSICIANS COURT-MARTIALED

Senator WILSON. Senator Kennedy?

Senator KENNEDY. Could you also provide the number of physicians who have been court-martialed for malpractice?

Dr. MAYER. Yes, sir, I will be happy to.

Senator KENNEDY. Do you know how many offhand?

Dr. MAYER. No, sir; I do not. I know in a number of cases there are not sufficient factual findings to warrant court-martial, but there is sufficient information to decredential that person and then his elimination from the service.

Senator KENNEDY. How many have lost their credentials? Do you know that?

Dr. MAYER. I cannot remember off the top of my head, but it is a substantial number in the last 2 years.

Senator KENNEDY. If you could provide that. Basically, I think you make the best of an indefensible case, quite frankly.

[The information follows:]

PHYSICIANS COURT-MARTIALED

The services estimate that about 12 physicians were court-martialed from CY 1982-84 for reasons relating to patient care, but not necessarily a specific act of malpractice. For the same time period, another 35 nonjudical punitive actions such as fines and letters of reprimand were taken.

The mechanism used to handle the vast majority of cases involving alleged, as well as actual, substandard medical care or improper conduct is decredentialing of providers, either temporarily or permanently.

We are in the process of analyzing the available data on decredentialing actions, but I am able to provide you with some preliminary data. From fiscal year 1983 through the 1st quarter of fiscal year 1985, decredentialing actions were initiated for about 240 DOD physicians. As of the end of the first quarter fiscal 1985, final action has resolved 168 of these cases. In 32 percent (54) of these resolved cases, the physician's full privileges were reinstated. The remaining 68 percent (114) of the resolved cases resulted in either a permanent limitation of certain privileges or revocation of all privileges.

CRIMINAL ACTION

Senator KENNEDY. If I may be so bold as to suggest, when you are talking about the Code of Military Justice, you are talking about criminal action. But here with medical malpractice we are talking primarily about negligence. To move from the standard of negligence to the standard of criminality is a very substantial leap.

That is why I find your argument very unpersuasive in I think you really switch the burden in terms of who ought to bear the burden when you deny the opportunity for military personnel to sue.

You indicate we are not going to see very much improvement in terms of quality because 80 percent of the treatment by military physicians is already open to suits because of their treatment of dependents and all the rest. You say that if we provide 20 percent the right to sue for negligent treatment that it won't really affect the quality.

But the fact is that you have to make the case why that serviceman ought to be denied the right to sue. The burden is on you, it is not on us to say that we believe that he ought to have it. You ought to have the burden to show why he ought to be denied it. I do not think that you have met that burden.

You talk about quality and say that we do not have to give them this right this morning because it is not really going to affect quality because quality is already there as a result of already-existing potential suits—because other people can still sue. So you say do not get worried about that.

Then you can go to the Uniform Code of Military Justice and try them as criminals if their conduct is that gross, or you can go to the inspector general. I will be interested in the statistics, the number of people who bring these cases and what happens to them.

I dare say the number of people who have lost credentials because of low-quality care is infinitesimal. It is infinitesimal across this country. It is the vast exception all across this country to delicense medical personnel for malpractice or negligence.

I will be interested to see what the record is in terms of the military. I will be very, very surprised if it is very much different. But to come back and respond to what I think is Senator Sasser's basic argument, why shouldn't these personnel be able to sue?

I still find it difficult to accept your presentation as rebutting the issue of fairness.

Senator WILSON. Mr. Gilliat has claimed, let us say, a fulsome response.

Dr. Mayer. May I say one thing first.

PRIMUS

Senator KENNEDY. I want to commend you by the way, on the Primus Program, the development of that new system of primary health care for the military.

Dr. MAYER. Thank you.

I just want to say that I am not here to rebut the assertion that the military should sue. I have not really said anything about that. That is not my point.

My point is that if you think that that is going to improve quality, then I think you are wrong. I do not think it is going to have any effect on quality. I am not arguing the merits of whether they should sue or not. That is Mr. Gilliat's job. [Laughter.]

Senator WILSON. With that happy introduction, Mr. Gilliat, you are on.

STATEMENT OF ROBERT L. GILLIAT, ASSISTANT GENERAL COUNSEL, MANPOWER AND HEALTH AFFAIRS

Mr. GILLIAT. Thank you, Mr. Chairman and Senator Kennedy.

First I ought to say that our general counsel, Mr. Chapman B. Cox, very much wanted to be with you today, but he had a conflicting hearing and he was unable to reschedule it.

Senator WILSON. You are the lucky one.

Mr. GILLIAT. I am the lucky one.

Senator KENNEDY. Mr. Chairman, I am afraid that I have to leave at noontime. You have been awful nice to indulge me at other times—and I have had a chance to look at Mr. Gilliat's full statement—and I wonder if you would indulge me for a minute, if Mr. Gilliat would also be willing to respond to that question.

Mr. GILLIAT. To the question you raised with Dr. Mayer?

Senator KENNEDY. Yes.

Mr. GILLIAT. In my oral testimony I have tried to focus on that a bit more. One thing the proposal ignores is that if you single out military personnel who are victims of malpractice for special compensation, you create a sanctuary or privilege for them that does not exist for the others, even those wounded in combat or injured in a training accident.

Why should it be that those who happened to have their leg injured in a hospital should be entitled to special compensation whereas the man who steps on a mine in a training accident is not entitled to additional compensation?

Senator KENNEDY. What is your argument—that because we make the system more equitable for some people, that we should make it equitable for all?

Mr. GILLIAT. That is right.

Senator KENNEDY. But the fact that we cannot make it equitable for every person at all times under every circumstance should not

prevent us from trying to make it equitable for at least those who suffer from malpractices in the military medical system.

Mr. GILLIAT. You can make it equitable for all. There ought to be adequate compensation for injury that the person receives or illness he or she suffers. We ought to fix the compensation system to take care of that if it is not adequate.

That is the way to solve this problem, not to single out a special group of cases.

Senator KENNEDY. It is not me singling them out; you are denying solidiers the opportunity to sue for malpractice. You are putting the burden again on me. But every other American has that right.

As I understand it, you say that because somebody is wounded on a battlefield and may lose their leg and should not have the right to sue, therefore, somebody who gets maltreated at Walter Reed should also not be given the right to sue. I find that extraordinary legal logic.

Then you say that their dependents have the right if they are victims of malpractice at Walter Reed. Yet if the same doctor does the same thing to the next bed down to a serviceman or woman—10,000 miles away from any battlefield—you are going to deny that person the same right. This has nothing whatsoever to do with combat in the field.

I thought we would try to reduce inequities in our system.

Mr. GILLIAT. We believe the compensation should not require proof of negligence. What we are doing is protecting the servicemember through compensation. That compensation system is not available to dependents or retired personnel.

That is the general trend in American law with no-fault compensation systems. Civilian personnel, should they be treated in a medical facility, would not be permitted to sue. Under the Longshore and Harbor Workers' Compensation Act the same is true, as it is under the Jones Act for the Merchant Marine.

We are not singling out military personnel. We are being consistent with the trend of no-fault compensation schemes.

Senator KENNEDY. Of course, those are matters that to a great extent are worked out through collective bargaining agreements.

Mr. GILLIAT. No, they are Federal statutes.

Senator KENNEDY. There are other kinds of agreements which are available to people that are involved in collective bargaining.

You are going to make recommendations about the compensation scheme?

Mr. GILLIAT. Yes. We have already had a study done by a contractor. The compensation system is not in balance. There are some inequities. In some other ways it is very good by comparison.

Senator KENNEDY. You are going to address that?

I will read your testimony. You are going to make recommendations about a new compensation scheme?

Mr. GILLIAT. We are not ready to make formal recommendations. We just received the completed study last week. We are going to move from that to formal recommendations. We will share the study with the subcommittee.

Senator KENNEDY. Are you going to actually propose recommendations to the various committees?

Mr. GILLIAT. Yes, eventually, sooner, I hope, rather than later.

Senator KENNEDY. When are you aiming for? Before the end of the year, or what?

Mr. GILLIAT. We have nothing prepared today. The disparity between the workmen's compensation and military compensation systems is basically in individual situations where a member of the Armed Forces does not have a family and where the benefits are not as large as they would be if he were able to bring malpractice action, and would get the benefit of pain and suffering, emotional distress, perhaps loss of consortium, if he were married, and disfigurement.

Those are benefits available under the malpractice system. They are generally not included in the military compensation system.

Senator KENNEDY. I thank the Chairman.

Senator WILSON. Thank you, Senator Kennedy, for your interest and for the time you have given this morning.

Mr. Gilliat, go ahead. I have read your written statement. Why don't you summarize it in addition to the response you made to Senator Kennedy.

Mr. GILLIAT. Thank you.

We are certain that those who advocate permitting active duty military personnel to sue the United States for medical malpractice do so for laudable reasons with which we can all empathize.

Yet, if we examine the justification for this position carefully, it is our conviction that their worthy objectives can be achieved without further opening the floodgates of tort litigation and, more importantly, without the destructive consequences to military morale and discipline that could flow from adoption of these proposals.

First, it is of concern to some supporters of the proposal that active duty military personnel are unable under the *Feres* doctrine to sue for medical malpractice when their dependants, retired personnel, and the dependents of those retirees are not similarly barred.

I have already addressed that issue in responding to Senator Kennedy. That answer, of course, is that there is a separate compensation system, available for the military personnel.

The concern for fairly compensating those who suffer illness or injury incident to their military duties is one we all share. To the extent that the compensation is not adequate—whether the condition requiring compensation is the result of medical malpractice or participation in an inherently dangerous training exercise—it must be improved.

The preliminary results of a recent DOD contractor study on the compensation system suggest that it does require adjustments to overcome imbalances and inadequacies for some beneficiaries.

We are prepared to work with this subcommittee and other agencies to improve the no-fault compensation system so that the benefits are fair to all, while preserving that system's essential qualities of directness, efficiency, and even-handedness. No member of the Armed Forces should be required to prove negligence in order to be compensated fairly for the injuries resulting from military service.

This no-fault compensation system for active duty military personnel is similar to other Federal no-fault compensation programs

in barring beneficiaries from bringing tort claims against the United States.

Thus, Federal civilian employees, seamen, and harbor workers and others covered by the Jones Act, the Public Vessels Act, and the Longshore and Harbor Workers' Compensation Act are also barred from suing under the Federal Tort Claims Act.

If Congress should change the exclusive remedy limitation applicable to military personnel through the *Feres* doctrine, is it prepared to change all of these other statutes in a head-long retreat to the 19th century from the 20th century concept of no-fault compensation?

The issue of discipline is perhaps the most difficult to discuss in the context of medical care. It is by no means immediately apparent that permitting military personnel to sue for medical malpractice constitutes a challenge to the military system of command.

Nevertheless, it is the conviction of those who have devoted their lives to military service that the cohesiveness, esprit de corps, and bonding essential to an effective fighting force cannot be preserved in the adversarial atmosphere of the courtroom.

Judges should not be asked to second-guess military decisions on fitness for duty, the competence of the health care staff in caring for the active duty force, or the need for prompter relief from duty to receive medical care.

If the bright line between military personnel and others is blurred by a chipping away at the *Feres* doctrine, it is virtually inevitable that the pressures will mount for a wholesale abandonment of that time-interest barrier to judicial interference with the operation of the Armed Forces.

This danger was well described, as follows, in a medical malpractice case arising in the ninth circuit:

"To determine the effect that a particular type of suit would have upon military discipline would be an exceedingly complex task * * *. The proximity of the injury to discharge would be only one factor. Whether it resulted from an allegedly negligent order would be another. Whether it was caused by totally unrelated military personnel would be yet a third. In short, nearly every case would have to be litigated and it is the suit, not the recovery, that would be disruptive of discipline and the orderly conduct of military affairs * * *. This is a particular situation where the drawing of a clear line is more important that being able to justify, in every conceivable case, the exact point at which it is drawn. *Henninger* v. *United States,* 473 F.2d 814, 815–816 (9th Cir. 1973).

Second, there is an understandable concern over the quality of military medical care that is traceable to several well publicized, distressing cases of medical malpractice, with their disastrous consequences for the victims and their families.

We have all been moved by these cases to ask what can be done to improve the quality of medical care in Department of Defense medical treatment facilities. Dr. Mayer has described to you in great detail what we are doing to fulfill Secretary Weinberger's order that all possible measures be taken to eliminate malpractice in military medicine.

That permitting more Federal tort claims is not one of those steps is a reflection of the conviction that such a measure would be,

at best, irrelevant. The tort claim process is such that it has little or no impact on medical care pvoviders, and their supervisors, who frequently have moved to other duties or have left the service before many of these claims are resolved.

But, more importantly, as Dr. Mayer has testified before this subcommittee, no doctor or other health care provider worthy of a place in military medicine differentiates in the nature of care provided on the basis of the patient's ability to sue for a mistake.

The quality of care is being improved equally for the 25 percent of our hospital patients who cannot sue under *Feres*, and for the 75 percent who can do so.

Third, those who question the desirability of the *Feres* bar in medical malpractice cases sometimes focus on the need for greater accountability to the unfortunate victims of such malpractice and their families, as you have done with your questions, Mr. Chairman.

Too often the impression may have been given that there was less interest in investigating and reporting on malpractice cases where no tort claim was possible. As Dr. Mayer has stated, the Department of Defense is committed to providing the maximum possible information on cases of unsuccessful medical care.

In addition, we will continue to be receptive to the ideas of those who suggest improvements in the accountability system. Just as it is vital to the quality assurance program to know that if anything were lacking in the medical care provided in any unsuccessful treatment, we recognize that the victims and their families have a right to know such information.

Authority to bring actions under the Federal Tort Claims Act, does not, and should not, increase that information nor enhance that accountability.

Finally, in summary, the Department of Defense for the following reasons opposes the evisceration of the *Feres* doctrine that would result if active duty personnel were permitted to sue under the Federal Tort Claims Act:

First, it would threaten the morale, discipline, and cohesiveness of the Armed Forces by the preferential treatment of one category of ill or injured active duty personnel.

Second, it would offer an uneven system of potential benefits based on differences in State law and on whether the unsuccessful medical care occurred in the United States or overseas.

As you observed before, those overseas cannot bring actions under the Federal Tort Claims Act. There is an additional difference in State law. Military personnel, of course, are ordered to be in the State where they are serving. This is different from the civilians.

Third, it would divert attention and resources from the current efforts to improve the quality of care for all who use military medical treatment facilities to the distractions of increased litigation.

Fourth, it would siphon funds for the benefit of a few members of the Armed Forces and their attorneys that should be dedicated to improving the comprehensive compensation system that exists for the benefit of all.

Thank you, and I would be pleased to respond to your questions.

[The prepared statement of Mr. Gilliat follows:]

PREPARED STATEMENT OF ROBERT L. GILLIAT, ASSISTANT GENERAL COUNSEL (MANPOWER AND HEALTH AFFAIRS), DEPARTMENT OF DEFENSE

Mr. Chairman and Members of the subcommittee: I appreciate the opportunity to present the views of the Department of Defense on proposals to modify the *Feres* doctrine. The bills that have been introduced in the Senate and House (S. 489 and H.R. 3174), though differing in some respects, would allow active-duty members of the Armed Forces to sue the United States for damages for certain injuries caused by improper medical or dental care.

At the outset, it is important to address the real issues raised by these bills: how do we deal with the General Counsel of the Department of Defense, Chapman B. Cox, has described as the "menace" of malpractice in the military health care system. We must assure that every effort is made to eliminate malpractice. This can be accomplished only by obtaining the best health care providers available, monitoring their work, and holding accountable those whose performance is substandard. The quality assurance initiatives that Dr. Mayer has described can accomplish those objectives; permitting military personnel to sue the Government for the errors of Defense physicians and dentists will not.

We share this Subcommittee's compassion for those who have been injured through medical treatment in our facilities and would welcome an opportunity to assist in identifying and correcting any deficiencies in existing compensation that may be identified. The Department of Defense strongly suggests, however, that the suits that these bills would authorize will neither improve the quality of medical care in the military nor achieve the just and equitable result for which we all strive.

In 1946, after three decades of legislative effort, Congress passed the Federal Tort Claims Act.[1] The primary purpose of the Act was to relieve Congress of the enormous burden created by the thousands of private relief bills seeking money damages for injuries caused by the Federal Government and its employees. Prior to the passage of the Act, such bills were the only means by which an injured individual could be compensated, because sovereign immunity blocked civil actions.

The Federal Tort Claims Act waives sovereign immunity in broad language. It makes the Government liable for tort claims based on the negligent or wrongful act or omission of any Government employee which acting within the scope of his or her office or employment. This liability is determined "in the same manner and to the same extent as a private individual under like circumstances."[2] There are some specifically enumerated exceptions to the general grant of tort jurisdiction, such as discretionary governmental functions, assault and battery, and claims arising in foreign countries.[3] However, no provision in the Act expressly permits or prohibits the claims of members of the Armed Forces.

Shortly after passage of the Federal Tort Claims Act, courts were faced with the issue of the servicemember's right to sue under the Act. In 1949, the Supreme Court held in the case of *United States v. Brooks*[4] that the plain language of the Act did not exclude claims by servicemembers. In *Brooks,* two brothers, both active-duty servicemen, suffered injuries in an automobile accident. They were on military leave and off base on a public highway when they were struck by a Government vehicle. The Supreme Court allowed suit under the Federal Tort Claims Act, but expressly limited its holding to claims that were not incident to the service of a military member. The Supreme Court reserved decision on the "wholly different case" of injuries that are incident to service.[5]

In *Feres v. United States*[6] the Supreme Court faced that "wholly different case." The *Feres* case involved a widow suing under the Federal Tort Claims Act for the wrongful death of her active-duty husband, who died in a fire while he slept in his military barracks. The Court unanimously held (Justice Douglas concurring in the result) that "the Government is not liable under the Federal Tort Claims Act for injuries to servicemen where the injuries arise out of or are in the course of activity incident to service."[7] In *Jefferson v. United States* and *United States v. Griggs,* which were companions to and decided at the same time as *Feres,* the Court held that the rendering of medical care by a military health care facility to an active-duty service member was incident to the service of that member.[8] The *Jefferson*

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[1] 28 U.S.C. §§ 1346(b), 2671 *et seq.* (1982).
[2] 28 U.S.C. § 2674 (1982).
[3] 28 U.S.C. § 2680 (1982).
[4] 337 U.S. 49 (1949).
[5] *Id.* at 52.
[6] 340 U.S. 135 (1950).
[7] *Id.* at 146.
[8] *Jefferson v. United States* and *United States v. Griggs,* 340 U.S. 135 (1950).

plaintiff had an abdominal operation that apparently was negligently performed. In *Griggs*, the executrix contended that her decedent died because of negligent medical care by Army surgeons.

Each of these cases involved a patient who was an active-duty member of the Armed Forces allegedly injured by others in the Armed Forces. The Supreme Court held that the Federal Tort Claims Act did not waive sovereign immunity in these cases.[9]

The Court focused in the *Feres, Jefferson,* and *Griggs* cases on the language in the Federal Tort Claims Act that makes the Government amenable to suit "in the same manner and to the same extent as a private individual under like circumstances. . . ." It concluded that the circumstances of the relationship between a servicemember and the Federal Government are not analogous to those of a private individual and that, accordingly, the Act did not create a cause of action for incident-to-service injuries. The Court reviewed, in the course of its opinion, several policy considerations that argue against giving the servicemember a right of action under the Federal Tort Claims Act, and it suggested that only an "express congressional command," which it did not find, would indicate that Congress intended to create such a right.

The major policy considerations that impressed the Court in *Feres* were:

(1) the effect of intramilitary suits on military discipline;

(2) the existence of a uniform and comprehensive system of statutory compensation and benefits available to servicemembers and their dependents or survivors; and

(3) the lack of uniformity of state laws.[10]

I would like to review these important policy considerations, which originally justified and continue to require the retention of the *Feres* doctrine and which are fully applicable to medical malpractice cases. However, the subject of *Feres* as it relates to medical malpractice has assumed such emotional proportions that any discussion requires the identification and analysis of facts which are frequently obscured.

First, interest in this subject has not been stimulated by an extraordinary rate of malpractice in military medical facilities. There is no respectable body of evidence establishing that military medicine is any more negligent than its civilian counterpart. Indeed, a recent study by the Office of the Assistant Secretary of Defense (Health Affairs) showed that, during 1983 and 1984, the rate of malpractice claims against military doctors brought by non-active duty patients for treatment received was about 6.4 per 100 physicians, in contrast to 16.5 per 100 physicians in civilian practice. An extrapolation that takes *Feres* into account by including claims that could be brought by active-duty members produces a rate of 8.7 per 100 physicians, roughly one-half the rate of civilian practitioners.

Second, even though DOD malpractice rates are relatively low, the Secretary of Defense is determined to eradicate malpractice in the military medical system. To that end, the Department has vigorously established a wide range of procedures to promote and monitor quality assurance.

Third, we are not opposed to increased benefits—indeed, we would favor them if they are shown to be necessary in light of changed economic conditions, but believe they should be provided within the existing compensation scheme. We fully support a system of benefits which provides adequate compensation for injured service personnel without damaging the fabric of military discipline that is essential to mission accomplishment.

Fourth, the concept of *Feres* is not unique. Its analogue prevails in workers' compensation statutes in virtually every state.[11] Similarly, within the Federal sector there are the Federal Employees' Compensation Act[12] and the Longshore and Harbor Workers' Compensation Act[13]—both of which provide for no-fault compensation of work-related injuries to the exclusion of tort remedies. These statutes exist for many of the same reasons that the Supreme Court originally enunciated in *Feres*, notably the need for a comprehensive, uniform, and predictable system of benefits. They reflect a broadly-based social and legal philosophy, whose objective is to protect the productivity and integrity of the workplace while adequately compensating injured workers.

Like their non-military counterparts, all active-duty military personnel injured incident to service are compensated, relatively quickly and in accordance with the

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[9] *Feres*, 340 U.S. at 141.

[10] L. Jayson, "Handling Federal Tort Claims," § 155.05 (1977).

[11] *See* generally, 2A A. Lawson, "The Law of Workmen's Compensation," §§ 65–67 (1983).

[12] 5 U.S.C. § 8116 (1982).

[13] 33 U.S.C. § 905 (1982).

same rules, apart from the divisive, expensive, time-consuming, and erratic process of litigation. Moreover, the bond between military superior and subordinate differs markedly from that of employer and employee, and it has long been recognized as far more special than commercial relationships born out of the marketplace. *Feres* is a judicial acknowledgment of this bond.

Inasmuch as the bills under consideration would partially set aside a doctrine that has served for 35 years, it is appropriate to return to the factors of the *Feres* rationable, questioning whether they are still valid. We think they are.

The first factor was the unique relationship of the soldier to his or her Government and unit. This relationship, as courts have traditionally recognized, is characterized by the requirements of discipline, order, and cohesiveness. In *Feres,* the extraordinary nature of the relationship led the Supreme Court to conclude that there was no analogous private liability upon which to predicate Federal Tort Claims Act relief. Elimination of *Feres* in favor of the litigative process would unquestionably erode this relationship. More simply stated, the bonding which is essential to an effective military organization cannot exist in an environment which allows and encourages its members to seek damages for the actions of their compatriots in the performance of military duties.

Significantly, either bill, if passed, would be the first statute to invite suit by a subordinate against the Government for the legitimate exercise of judgment by a superior. The door to the Federal courts would swing open to any servicemember upon the bare allegation of medical malpractice in a hosptial. We foresee a proliferation of litigation, not only to remedy injuries caused by malpractice, but also to ventilate other grievances.

This concern is supported by experience with litigation following the Supreme Court's creation of a Federal cause of action for violations of constitutional rights. According to statistics recently provided by the Department of Justice, there have been at least 12,000 constitutional tort lawsuits. Some 2,600 of these are still pending and involve over 10,000 Federal employees. Against this mass of litigation are only 29 verdicts favoring plaintiffs. Some of these have been overturned on appeal, while others are still under appellate review.

Ironically, to protect the Armed Forces and Federal civilian workforce from this disruption, in 1982 the Supreme Court relied heavily upon the rationale of the *Feres* doctrine in erecting a similar jurisdictional bar in *Chappell* v. *Wallace* [14] and *Bush* v. *Lucas.* [15] Until these decisions, dissatisfied military members and Federal employees with increasing frequency used and abused the concept of constitutional tort to challenge their supervisors.

At first blush, widespread challenges to military decisionmaking would appear remote from entitling servicemembers to sue for medical malpractice injuries. However, military care practitioners often make determinations upon which commanders rely. The resulting decisions of the commanders frequently are contrary to the personal desires of the member and may have an adverse economic impact on the member. Under the proposed legislation, any such decision might become subject to attack in a tort action alleging that a negligent medical finding resulted in physical discomfort and emotional distress. Indeed, in some jurisdictions, an allegation of emotional distress alone would suffice.

Each decisionmaking process within the military provides an avenue of appeal or review while still preserving the essentials of discipline and chain of command. Permitting malpractice actions by active-duty members would create the specter of a collateral means to attack these time-tested grievance-handling procedures in any case involving a medical determination.

The implications of changing the *Feres* doctrine are far more extensive than a cursory examination would suggest and unfortunately go far beyond providing tort remedies for extraordinarily grievous injuries. Numerous administrative actions and command decisions are directly dependent upon medical determinations made in hospitals operated by components of the Department of Defense.

Several hypothetical cases illustrate the potential for misplaced attacks upon military decisions through resort to Federal Tort Claims Act suits under the proposed bills. Consider the following:

a. A pilot physically disqualified from flying status sues, alleging that a negligent medical error caused emotional distress. If brought in a jurisdiction which permits an action for negligent infliction of emotional distress, this action could provide an

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[14] Chappell *v.* Wallace, 462 U.S. 296 (1983).
[15] *Bush* v. *Lucas,* 462 U.S. 367 (1983).

otherwise unobtainable judicial forum to challenge a military personnel assignment decision through litigation.

b. An officer disqualified from nuclear weapons duty as a result of a medical examination sues for emotional distress on the theory of medical negligence. Should we subject the selection of personnel for highly sensitive duties to protracted and unpredictable tort litigation?

These examples should serve to point out that the implications of permitting malpractice suits by active-duty members go far beyond furnishing a money-damage remedy for physical injuries. Although the attack on command decisions is particularly objectionable in these hypothetical cases, the potential for incursions into command prerogatives would exist if any intramilitary damages litigation is authorized under the Federal Tort Claims Act. All medical decisions in the United States and the actions which flow from them could become fair game in Federal Tort Claims Act actions under the existing bills. The administrative process would become a turmoil, and personnel determinations affecting a member's status could remain in limbo for lengthy periods until judicially resolved.

A second factor in the *Feres* rationale is the lack of uniformity in state laws or, more positively, the desirability of uniformity in dealing with all service-connected injuries. The Supreme Court noted the unfairness which would result if the remedy for these injuries were determined by the fortuitous location of the member's assignment. Inasmuch as the Federal Tort Claims Act provides a tort remedy based upon the law of the situs state, the Supreme Court recognized that identical injuries could have dramatically different results. While civilians choose to be where they are, active-duty military members are not free to select their locations.

Under the bills, remedies and results would depend upon location. A cause of action and recovery would be made subject to the vagaries of more than 50 different sets of local laws. Moreover, recovery would be denied to those injured overseas because of the "foreign country" exception of the Federal Tort Claims Act. Likewise, recovery would become dependent upon such incalculables as regional bias, philosophical disposition of the judge, ingenuity of counsel, and workload of the United States Attorney's office. Such a formula, in our view, neither provides fairness nor supports the positive values necessary for the preservation of military esprit de corps. Ironically, reliance upon the traditional tort system is increasingly questioned in states that are struggling with the well-publicized problems it has created.

The third factor in the *Feres* rationale is the existence of a comprehensive, no-fault compensation system of military and veterans' benefits. As already noted, virtually every state has statutorily affirmed its preference for this approach. Moreover, the Congress has previously agreed by passing the Federal Employees' Compensation Act and the Longshore and Harbor Workers' Compensation Act, each of which provides for exclusive no-fault remedies for job-related injuries.

Other impacts, not specifically considered by the *Feres* Court but which cannot be ignored, are human and financial costs. Aside from judgments that are open-ended and frequently bear no logical relationship to the extent of physical injury, the potential indirect burdens are significant. Any increase in litigation will result in a commensurate increase in the legal staffs of all military branches and the Department of Justice. Additional medical personnel would also be necessary, not for patient care but to assist in defending such litigation. Moreover, the disruption to military readiness caused by the attendance of servicemembers as witnesses and litigants at trials, many years after the event, could well impair mission performance.

We share fully your heartfelt concern for those injured through medical malpractice. As Dr. Mayer and the Surgeons General have demonstrated, the Department has taken strong steps to minimize medical injuries and to provide top-quality care. We are convinced that the solution to the medical malpractice problem is through aggressive quality assurance measures such as those that the Department has instituted in recent years.

In conclusion, broadening Federal Tort Claims Act coverage to permit litigation by servicemembers would not deter medical malpractice. Instead, such a step would foster divisiveness within military units by inviting soldiers to sue for damages based on their superiors' actions.

For these reasons, the Department of Defense opposes legislative modification of the *Feres* doctrine.

Senator WILSON. Thank you, Mr. Gilliat.

I have some questions that in the interest of time I will submit to you for the record.

COMPENSATION

Let me just come back to what I think is your basic point, or one of them, and that is having to do with what you see as an inequity if compensation were made under the Sasser proposal to those suffering military malpractice, a remedy denied to the recipient of combat wounds.

I suspect you are on weak ground there and I will tell you why I think so. I think there is a distinction. We, even when not dependent on our All-Volunteer Force, have in time of emergency asked the young men and women whom we have in the armed services to face the distinct possibility that they will not only suffer wounds, but perhaps even sacrifice their lives in the defense of their country.

That is not what we ask of someone who goes to sick call. That is not what we ask of someone in an operating room. Obviously, I think that there is a danger in most analogies, the danger being that it is not really an analogous situation when you stop to analyze the offered analogy.

It seems to me that there is more to be said on your side in the statistics that Dr. Mayer offers with respect to the difference in the incidents of malpractice suits brought by those within the military health care system who are allowed to bring such suits and a larger civilian populace that is outside the military health care system.

But I think in one instance what we are talking about is the effort to hold accountable that class who is responsible for the injury suffered. In one case it is the enemy that is inflicting injury and over a far greater number, hopefully, than in the case of medical malpractice.

TORT LIABILITY

We have another thing and this is one of the reasons that people feel quite emotional about it. There is a special standard of care in the law of tort liability, as best I remember it, and it has been longer than 8 years in my case since I have practiced law, so I have sympathy with Senator Sasser, but there is a special standard that would apply at least in the common law to those who held themselves out as offering to the public a special standard and a standard of care to which they were held exceeded that of the ordinary care that was required of the so-called prudent man.

That has traditionally applied in the cases of the profession because the professions, be they law, medicine, whatever, through a credentialing process also offer to the public some assurance that there was a higher than usual standard of care to that standard, the proferred standard that they have been held to by common law and subsequently by tort law.

What we are saying is that we expect more of physicians. If I take shirts to the laundry and they butcher them, as is ordinarily the case, nothing much comes of that because while I am irritated about it, the fact is the injury that it has done to the shirt is not of great magnitude in the larger scheme of things.

If I am a parent of a son or daughter who in the course of military service receives a grevious injury at the hands of a medical

practitioner, I am going to be outraged. I will probably be more outraged than I would be if I were the parents of the same son or daughter who as a result of negligence on the part of a platoon sergeant sustains an equally serious injury.

I may raise hell about that in both cases, but in the one instance, unless the negligence on the part of the platoon sergeant is really gross and unless the platoon commander and company commander were out doing something other than supervising that training, I probably am going to feel, as much as it pains me, that there is a lesser degree of injury, if not physically, at least in terms of surrounding that injury, than where there is serious medical malpractice because I expect more from that physician.

There is a real emotional quality to this and I think we all recognize that and arguably there should be because it is recognized even in the law. But what we really want here is accountability, which is why I am interested in the statistics that I have asked Dr. Mayer to provide because on the other side I do think that what we want is prevention and not blood money.

As far as I am concerned, our society is the weaker and definitely the poorer because we are engaged in a legislative and litigative binge, and as a member of the legal profession, there is a part of it of which I am not very proud.

What we are seeking in these hearings, and I assume what the Judiciary Committee will seek when they address the Sasser proposal, is to try to pass legislation or perhaps not pass it, to bring about a reform that will result in the prevention of the kind of horror stories which we have read about and which we will hear about today.

I am more than interested, I am delighted to learn that you have undertaken, independently a study aimed at reforming the disability system because I think it is necessary.

INEQUITIES OF SYSTEM

I think there are some real inequities in the system now. I do not think there is any particular logic or justice to the fact that a loss of a hand is of less importance to a private than to a regimental commander.

There is a good and sufficient reason for compensating them differently for what they do professionally. There is not, in my judgment, the same basis for compensating them differently for injury.

In any case, we will eagerly await the results of your study. I commend you on it. I am genuinely eager to see it.

I do think that the argument you make with respect to differentation in circumstance of the combat soldier who sustains a grevious wound and the grevious wound sustained at the hands of physician is really a very valid point.

SASSER PROPOSAL

I will have to tell you that even though I am not persuaded that necessarily the Sasser proposal is the way to go. It is wedded to the Federal Tort Claims Act which for better or for worse puts the plaintiff at the mercy of the law of the situs so that in Tennessee he may have one remedy whereas if he is injured at Fort Knox in

Kentucky, he will have a totally different remedy for the same injury.

If he is injured overseas; let us say he is the recipient of malpractice in a military hospital in Wiesbaden, he would have no redress under the Federal Tort Claims Act.

For the record I will submit some written questions. I think what we should be focusing on—and I will make a statement and not pursue further questioning because we do have other witnesses and time is running quickly is that—we have to be assured of accountability in order to achieve prevention.

I think that the painful, the heartbreaking testimony that we will hear will make it clear that that is a goal shared by those who bring us that testimony. A wrongful death action does not bring anybody back.

Mr. Gilliat, if you have anything you would like to add, we will be happy to have it. Otherwise, we will excuse you and Dr. Mayer.

Mr. GILLIAT. I will certainly concede the analogy is not exact. What we were trying to do is suggest that the compensation suggested in this legislative proposal should be as much for those who are injured in a training accident or actually in battle as for those who may be victims of malpractice incident to their service.

Senator WILSON. I think we need to work on both. It may be that if Senator Sasser's proposal is not the answer, at least it has done a considerable service by focusing attention that was focused in other ways as well.

I think we do have to improve the compensation for injury sustained in a variety of ways.

I also think that we have to do whatever is humanly possible to prevent the kind of malpractice which I hope is rare. For that reason we will be working closely with Dr. Mayer and the Surgeons General to see that we devise that procedure.

[Questions submitted by Senator Kennedy follow:]

QUESTIONS SUBMITTED BY SENATOR EDWARD M. KENNEDY

Senator KENNEDY. You point out in your testimony that nonactive duty patients—dependents for example—have the right to sue the United States for medical malpractice, but that the rate of malpractice claims brought by such individual was about 6.4 per 100 physicians—as compared with 16.5 per 100 physicians in civilian practice.

And you say that if active duty members had the same right, the rate would be roughly one-half the rate of civilian practitioners.

And then you argue that if the *Feres* doctrine were repealed, there would be a proliferation of litigation.

Are not these two positions inconsistent?

If 80 percent of the individuals presently treated by military facilities have the right to sue at the present time, how would the addition of the balance of individuals, the 20 percent who are active duty service personnel, generate any significant "proliferation"?

Mr. GILLIAT. During fiscal year 1985, 308 suits and 968 administrative claims for medical malpractice were filed against the Department of Defense, for a total of 1,276 cases. If the number of the Department's medical beneficiaries who may sue were increased by twenty percent, it is reasonable that the number of cases would increase by the same factor. Thus, if the *Feres* doctrine were to be repealed, the Department would probably experience a sharp rise in medical malpractice cases, perhaps in the range of 255 additional claims and actions.

Indeed, as I have discussed in my statement, the expansion of cases might even be more drastic. Some plaintiffs may seize upon the repeal of the *Feres* doctrine as an opportunity to challenge command decisions that are based on medical determina-

tions. Although we cannot predict the volume of these "back door" attacks on military discipline, we do know that, in whatever number, they will tear at the fabric of military discipline and cohesiveness that are necessary in any fighting force.

Senator KENNEDY. Referring to your examples on page 10 of your testimony, you cite the problem of a pilot who is physically disqualified from flying because of a negligent medical error. You say that if permitted to sue, this action could provide an otherwise unobtainable judicial forum to challenge a military personnel assignment decision through litigation.

But that is not the real question here—the personnel assignment. The real question that such a pilot should be permitted to test is whether he was the victim of medical malpractice—not whether he should have been permitted to fly an airplane after being victimized.

If an Air Force doctor negligently cuts off a pilot's leg, no one is going to second-guess the Air Force's decision that he should no longer be a fighter pilot.

Repeal of the *Feres* doctrine would only allow the pilot to show medical malpractice and to argue that, by destroying his ability to pursue his chosen profession, i.e., flying jet fighters, he has experienced substantial emotional distress as well as physical pain. I see nothing wrong with allowing that.

Do you have any comment?

Mr. GILLIAT. If the *Feres* doctrine were to be eviscerated, the bright line that has insulated military decisions from judicial review would be destroyed. Consider the hypothetical situation that I described in my statement and to which you referred in your question as an example of what could happen without *Feres*. A pilot who has been medically disqualified from flying sues for medical malpractice. This lawsuit would unavoidably involve the court in assessing the wisdom of the personnel decision. It would also unfairly create a privileged class of military personnel—those who are able to seek judicial relief from command decisions merely because those decisions are linked, however tenuously, to medical recommendations. Your question accurately recognizes that the real issue in the pilot's lawsuit is a medical finding "destroying his ability to pursue his chosen profession."

Senator KENNEDY. With respect to your second example on page 10, you talk about an officer who has been disqualified from nuclear weapons duty because of a medical screening examination.

But repeal of the *Feres* doctrine with respect to medical malpractice would have no impact on the question of screening military personnel for assignments within their services. A service man or woman may disagree with the results of such a screening examination, but under no theory of negligence would that person be viewed as being a patient who has suffered from medical malpractice.

What I am saying is that repeal of the *Feres* doctrine would not, as you suggest, allow active duty personnel to test personnel decisions within the military. It would only permit them to recover damages suffered when, as patients in military facilities being treated by military personnel, they are victims of negligence and malpractice.

That is far different from disagreements with medical screening tests and resulting job assignments.

Mr. GILLIAT. Repealing the *Feres* doctrine would have the same effect on screening military personnel for nuclear assignments as it would on physical evaluations of pilots. In both cases, the doctrine assures that commanders are able to make necessary personnel decisions without fear of later harassment in the Federal courts by disappointed subordinates. The danger in both instances is not so much the fear of a judgment, which, after all, would be paid by the United States, but the prospect of protracted litigation, often years after the events in question occurred. The real losers will be the American people. They will lose the decisive leadership and flexibility that they expect in their Armed Forces.

Senator WILSON. Thank you very much gentlemen.

Next we will call to the witness table Dr. O'Brien, Mrs. Day and Dr. Skillicorn.

Dr. O'Brien, we will begin with you. Dr. Janet O'Brien is the spokeswoman today for the National Association of Military Families. She serves as director of their research program.

STATEMENT OF JANET O'BRIEN, PH.D., DIRECTOR OF RESEARCH, NATIONAL ASSOCIATION OF MILITARY FAMILIES

Dr. O'BRIEN. Mr. Chairman, I welcome this opportunity to express our views on military health care.

NMFA is fully aware that wartime readiness is the primary mission of the military health services system. We support this mission.

At the same time, the system has the responsibility to provide quality medical care and cost-efficient health care delivery to all eligible beneficiaries. The present system is unable to maintain both the wartime and the peacetime mission.

NMFA representatives recently conducted a medical survey. This survey noted the following problems:

One. Access to the direct care system.

Two. Preventive care.

Three. Continuity of care.

Four. Mental Health.

Five. CHAMPUS.

One. Access to the direct care system. The direct care system cannot handle the number of beneficiaries who are eligible. At one stateside military hospital in July 1985 there were 10,902 inquiries made and only 1,868 appointments granted. Confusing appointment systems are prevalent.

For example, cardiology appointments are made on the 23rd of each month at 7:30. Appointments for GYN and Pap smears are made on the 14th of each month at 7:30, except postparum, post-op and OB registration appointments which are made daily at 7:30 and must be booked one month in advance.

The rationale given for the confusing appointment system in this case is that the hospital would rather disappoint people unable to obtain appointments only once a month rather than on a daily basis.

Waiting time for special appointments present another access problem. Examples include a 4 to 6 months wait for mammograms, after referral by surgical or OB/GYN specialists, 3 to 4 months for ENT appointments for orthopedics take up to 2 months.

In order to provide more direct care for outpatients, the Army began testing a contracted primary care center, called PRIMUS, on October 1, 1985. It serves the Fort Belvoir, Virginia, catchment area. The cost of an outpatient visit in the Fort Belvoir catchment area is up to $108.

Based on 36,000 visits per annum, the cost of an outpatient visit at PRIMUS is expected to be $47. a savings of $61 per visit will result. Because PRIMUS is designed to provide primary care only, the problem of accessibility to the secondary level, specialists, remains.

Our recent survey of the system found that in all three services, both stateside and overseas, many clinic emergency rooms are closed after duty hours. The only access the military family has to medical attention after duty hours is the emergency room.

These emergency rooms are closed because they lack trained emergency room personnel. Overseas, these clinic closings require

the family to travel long distances, up to 1½ hours, to the military hospital.

Their other option is to use local medical care through CHAMPUS. In Europe, these closings have caused CHAMPUS costs to the beneficiary and the Government to increase dramatically.

The language barrier is the greatest problem for the family forced to use local medical care overseas. Describing medical symptoms in a foreign language is almost impossible in an emergency.

The most significant result of emergency room closings is the very real potential for loss of life.

Two. Preventive care. Neither the direct care system nor CHAMPUS provides nonactive duty beneficiaries with sufficient preventive care. Current medical literature indicates that preventive care can detect problems at the primary level, saving more costly care at the tertiary level. Preventive care is a valid cost containment measure.

Dental care is a major part of preventive medicine. Dental care is available for family members overseas and at certain sites in the United States. Other beneficiaries obtain treatment at military facilities on a space available basis.

There are not enough dentists in the system to provide the care. For example, at one military installation there are 5,000 families on the dental clinic waiting list. At another installation, the dental clinic uses a lottery system to ensure fairness for the approximately 50,000 to 60,000 beneficiaries.

With five staff dentists, it can only serve 70 families a month. A dental insurance plan is vital to the dental health of all eligible beneficiaries.

Three. Continuity of care. Patients are transferred from one doctor to another and one system to another. Frequent transfers preclude a consistent doctor-patient relationship and disrupt the continuity of care at a crucial time during treatment. Duplication of services leads to increased costs.

Four. Mental health. Mental health care has been a relatively neglected part of the military medical system. Where mental health care is unavailable, it is probable that mental disorders account for at least part of the high rate of usage of general outpatient medical facilities, dispensaries and emergency rooms.

Sufficient mental health care at the primary level will prevent costly treatment at the tertiary level.

Five. CHAMPUS. CHAMPUS functions under the policy guidance and operational direction of the Assistant Secretary of Defense (Health Affairs). CHAMPUS contracts with fiscal intermediaries to provide for the processing and adjudication of claims for eligible beneficiaries.

The costs to the beneficiary are a yearly deductible of $50 for one person or $100 for a family. Active duty family members then pay 20 percent of allowable charges for outpatient care after the deductible. Retirees and their families pay 25 percent.

For inpatient care, active duty families pay a fee per day or $25, whichever is more. Retirees and their families pay 25 percent of allowable charges. The beneficiary is liable for any charges CHAMPUS disallows. For example, in the Washington, D.C., area it is es-

timated that a CHAMPUS beneficiary pays 40 percent of the total cost of outpatient care.

Most doctors and hospitals will not accept CHAMPUS assignment. The percentage of physicians in the United States who accepted CHAMPUS assignment for outpatient care in fiscal year 1984 is 27.3. For inpatient care, the percentage is 39.3.

These percentages include physicians who accepted CHAMPUS assignment only once. Health care providers refuse to accept CHAMPUS assignment because of low allowable rates and consistently late payments.

Any statement pertaining to authorization of care given to a beneficiary by CHAMPUS or its representative is not legally binding. The beneficiary discovers this only when his claim is denied. The only legal authority is the CHAMPUS regulation. The beneficiary assumes all payment responsibility.

CHAMPUS beneficiaries, physicians and their health care providers deserve the same prompt response and binding decisions that apply to civilian sector group health participants.

Medical care is an entitlement for those serving in the Armed Forces and their dependents. Affordable medical care is not a reality for our families. They have limited access to direct care and cannot afford care under CHAMPUS.

Military families put up with long waits for appointments and treatment, because they cannot afford to use CHAMPUS. If forced to pay even more medical costs under Medicare allowables, many military families will be financially ruined.

The proposal to increase the beneficiary share of CHAMPUS costs comes at a time when military families already pay high out-of-pocket costs for PCS moves. Military spouses are unemployed at a rate of 17.8 percent stateside and double that overseas.

When military benefits are rapidly eroding, military families cannot subsidize their military medical entitlement by using 1 month's pay per year to cover civilian health care costs.

There is no room in a military family's budget for unpredictable costs. The problems we have addressed in this testimony should be corrected without increased cost to the beneficiaries.

A catastrophic illness could bankrupt the service member and his family in a very short time. NMFA recommends a catastrophic cap of $1,000 yearly per active duty family, and $3,000 yearly per retired family.

This is a crucial time for military families as DOD reviews the health care delivery system. There is no focal point within DOD for issues relating to military family health care. NMFA recommends that military families be represented in DOD at the policymaking level.

Medical services should be made more accessible for our families. NMFA encourages DOD to take advantage of the buyer's market in health care by developing such programs as health maintenance organizations, preferred provider groups, and fixed-price contracts, such as outpatient care centers.

NMFA supports expansion of medical services for military families overseas. Families overseas deserve the same quality medical care available in the United States.

While the NMFA fully supports increased wartime medical readiness, there are dangers in a system where civilian providers deliver outpatient care and the military direct care system provides inpatient care. The building of skills for wartime readiness should not influence surgical and other treatment decisions.

NMFA supports the dismantling of CHAMPUS. CHAMPUS is ineffective, unreliable and costly to the beneficiary, health care providers, and the Government. CHAMPUS is an unnecessary middleman. NMFA recommends that the Department of Defense explore viable, less costly alternatives to the present military health care system.

NMFA intends to continue studying military family health care and will be available for consultation.

Thank you for allowing us to present this testimony.

[The prepared statement of Dr. O'Brien follows:]

PREPARED STATEMENT OF JANET F. O'BRIEN, PH.D., DIRECTOR OF RESEARCH, NATIONAL MILITARY FAMILY ASSOCIATION

The purpose of Chapter 55, Title 10, United States Code (USC) ". . . is to create and maintain high morale in the uniformed services by providing an improved and uniform program of medical and dental care for members and certain former members of those services, and for their dependents." Paragraph 1079 authorizes the Secretary of Defense, after consulting with the Secretary of Health and Human Services and the Secretary of Transportation, to contract for medical care for the spouses and children of active duty members. Paragraph 1066 extends this authority to retirees, their families, and survivor families. There are approximately 8 million eligible non-active duty beneficiaries of the military medical care system.

NMFA is fully aware that wartime readiness is the primary mission of the military health services system. We support this mission. At the same time, the military health services system has the responsibility to provide quality medical care and cost-efficient health care delivery to all eligible beneficiaries. At the present time, the military health services system is unable to maintain both the wartime and the peacetime mission.

NMFA representatives recently conducted a medical survey. This survey noted the following problems in the military health services system:

1. Access to the direct care system
2. Preventive care
3. Continuity of care
4. Mental Health
5. CHAMPUS.

1. Access to the direct care system. The direct care system cannot handle the number of beneficiaries who are eligible. For example, at one stateside military hospital, in July 1985, there were 10,902 inquiries made and only 1,868 appointment granted. Most appointments are made in a confusing way. For example, cardiology appointments are made on the 23rd of each month at 0730. Appointments for GYN and Pap smears are made on the 14th of each month at 0730, except postpartum, post-op and OB registration appointments which are made daily, at 0730, and must be booked one month in advance. This appointment schedule which is attached as Enclosure 1 is not readily available to hospital users. The rationale given for this confusing appointment system is that "the hospital would rather disappoint people unable to obtain appointments only once a month rather than on a daily basis."

Waiting times for special appointments present another access problem. Examples include a 4-6 month wait for Mammograms, after referral by surgical or OB/GYN specialists, 3-4 months for ENT appointments, and up to 2 months for orthopedics.

In order to provide more direct care for out-patients, the Army began testing a contracted primary care center, called PRIMUS, On 1 Oct 85. It serves the Ft. Belvoir, VA, catchment area. A catchment area is the area within a 40 mile radius of a military treatment facility (MTF). The cost of an outpatient visit at the Ft. Belvoir Hospital is $108. Based on 36,000 visits per annum, the cost of an outpatient visit at PRIMUS is expected to be $47. A savings of $61 per visit will result. Use of PRIMUS instead of CHAMPUS spares the beneficiary from paying an average of 40% of the cost of an outpatient visit to a non-military provider. Because PRIMUS is designed

to provide primary care only, the problem of accessibility to the secondary level (specialists) remains.

Our recent survey of military medical care found that in all three services, both stateside and overseas, many clinic emergency rooms are closed after duty hours. The ONLY access the military family has to medical attention after duty hours is the Emergency Room. These emergency rooms are closed after duty hours because they lack trained emergency room personnel. Overseas, these clinic closings require the family to travel long distances (up to one and a half hours) to the military hospital. Many families overseas do not have private vehicles. Their other option is to use local civilian facilities where the language barrier is the greatest problem. Describing medical symptoms in a foreign language poses an insurmountable problem in an emergency. (See Enclosure II) The most significant result of ER closings is the very real potential for loss of life.

2. Preventive care. Neither the direct care system nor CHAMPUS provide non-active duty beneficiaries with sufficient preventive care; that is, screening and detection procedures such as cholesterol levels, blood sugar levels, baseline mammograms, and EKG's. Current medical literature indicates that such screenings can detect potential problems which can often be treated non-medically, for example, dietary changes. Preventive care is a valid cost containment measure.

A major part of preventive medicine is dental care. Dental care is available for family members overseas and at certain sites in the United States. Other family members, retirees, their family members, and survivor families obtain dental care at military facilities on a space available basis. Space-available dental care cannot begin to meet the needs of the eligible beneficiaries. There are not enough dentists in the military system. For example, at one militay installation there are 5,000 families on the dental clinic waiting list. At another installation, the dental clinic uses a lottery system to insure fairness for the approximately 50–60,000 beneficiaries. With five staff dentists it can only serve 70 families (approximately 150–200 people) a month.

Since many military families cannot afford dental care, they postpone going to the dentist until they serve overseas. After years of neglect, the treatment needed is extensive and, therefore, extremely costly to the military medical system. A dental insurance plan on a cost-sharing basis is vital to the dental health of all eligible beneficiaries.

3. Continuity of care. Another problem for both doctors and patients is continuity of care. Patients are transferred from one doctor to another. Frequent transfers preclude a consistent doctor-patient relationship, and prevent the doctor from following a complete course of treatment. When speciality treatment is unavailable in the direct care system, the patient must seek a civilian specialist. When the civilian specialist decides hospitalization is necessary, the patient must request a nonavailability statement (NAS). A nonavailability statement is a form from a military hospital that says it cannot provide the in-patient care needed. When the in-hospital portion of the treatment can be provided by the military hospital, the patient must return to the direct care system, disrupting the continuity of care at a crucial time during treatment. This is extremely disturbing to both patient and physician and can cause duplication of services which leads to increased costs.

4. Mental Health. Mental health care has been a relatively neglected part of the military medical system. Overseas, the social disruption isolations from family and spouse, lack of support systems and cultural shock all serve to increase the likelihood of mental disorders. Where mental health care is unavailable, it is probable that mental disorder account for at least part of the high rate of usage of general out-patient medical facilities, dispensaries and emergency rooms. In the United States, civilian mental health professionals provide out-patient care. In the Tidewater VA, San Diego CA, and Washington DC area most CHAMPUS benefit dollars are spent for mental health care. CHAMPUS problems in the mental health care area will be addressed in the CHAMPUS section of this testimony.

5. CHAMPUS. CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) is a program administered by OCHAMPUS (Office of the Civilian Health and Medical Program of the Uniformed Services). Designated a field activity, OCHAMPUS functions under the policy guidance and operational direction of the Assistant Secretary of Defense (Health Affairs). CHAMPUS contracts with fiscal intermediaries (FI's) to provide for the processing and adjudication of claims for eligible beneficiaries. The per annum costs to the beneficiary are a yearly deductible of $50 for one person or $100 for a family. Active duty family members pay 20% of allowable charges after the deductible; retirees and their families pay 25% of allowable charges. The beneficiary is liable for any charges CHAMPUS disallows.

Some doctors and hospitals will accept CHAMPUS assignment. This means that they will accept whatever CHAMPUS rules to be an allowable charge. The percentage of physicians in the United States who accepted CHAMPUS assignment for outpatient care in FY 1984 is 27.3 (it should be noted that this percentage includes physicians who may have accepted CHAMPUS only once). Health care providers are reluctant to accept CHAMPUS assignment because of low allowable rates and consistent late payment. When doctors and hospitals do not accept CHAMPUS assignments, the beneficiary must pay all costs above the amount allowed by CHAMPUS.

Each military treatment facility (MTF) has a Health Benefits Advisor (HBA) who can be either civilian or military. The HBA is not employed by CHAMPUS but directly by the MTF and performs this function as an additional duty. The HBA is the recommended first contact for the beneficiary, and in most cases, does not have copies of the CHAMPUS regulation. The second contact is the fiscal intermediary. Each fiscal intermediary in the United States has toll-free service. Overseas, the CHAMPUS representatives do not have this service. The third contract is OCHAMPUS in Aurora, Colorado which does not have toll-free service.

Any advice given to a beneficiary by CHAMPUS or its representative is not legally binding. The only legal authority is the CHAMPUS regulation. The beneficiary assumes all payment responsibility. CHAMPUS beneficiaries, physicians and other health care providers deserve the same prompt response and binding decisions that apply to civilian sector group health participants.

Secretary of Defense Weinberger recently states, ". . . medical services can be made more accessible to our families". "I foresee several programs developing. They could include enrollment in health maintenance organizations, preferred provider groups, fixed price contracts, under which civilian insurers would pay for our beneficiaries health care and the use of easily accessible out-patient care centers such as that being established by the Army here in Northern Virginia." NMFA supports Secretary Weinberger's suggestions. The problems we have addressed in this testimony should be corrected without increased cost to the beneficiaries.

Medical care is an entitlement for those serving in the Armed Forces and their dependents. In fact, free medical care is not a reality. At present there is no cap on the amount of money for which the beneficiary is liable. A catastrophic illness could bankrupt the service member and his family in a very short time. NMFA recommends a CHAMPUS catastrophic cap of $1,000 yearly per active duty family, and $3,000 yearly per retired family.

NMFA supports expansion of medical services for military families overseas. Families overseas deserve the same quality medical care available in the United States.

While the NMFA fully supports increased wartime medical readiness, there are dangers in a system where civilian providers deliver out-patient care and the military direct care system provides in-patient care. Moving between the two medical care systems disrupts the continuity of care. Also, in order to insure wartime readiness, more physicians must receive surgical training. However, the building of skills for wartime readiness should not influence surgical decisions.

NMFA supports the dismantling of CHAMPUS. It is not a cost effective system either for the government or for the beneficiary. CHAMPUS is an unnecessary middleman. NMFA recommends that the Department of Defense explore viable, less costly, alternatives to the present military health care system. The Secretary of Defense has the authority "to contract for medical care under such insurance, medical service, or health plans as he considers appropriate", under Title 10, Chapter 55, USC.

Thank you for allowing us to present this testimony.

This listing is provided for information in utilizing the Central Appointment System. The days, dates and times signify when new appointments are released; however, you may call at any time for an appointment. Active duty soldiers will receive preference for appointments. To cancel appointments, call 396-2932/6773. Thank you for your cooperation.

Allergy—Contact Allergy Clinic for appointments/information. 396-4674/3514

Audiology—Thursday, 1230 (weekly). Referral required. 396-1241/436-1272

Brace Shop—No appointment necessary. Referral required.

Cardiology—23d of each month, 0730. Appointments limited. Referral required. 436-1173, 396-1351/0341

Dental—Retirees and their dependents only. Tuesday & Friday at 1230. 396-1241/436-1272

Dermatology—Wednesday, 1230 (weekly). Referral required. 396-1241/436-1272

ENT (Ear-Nose-Throat)—Wednesday, 1230 (weekly). Referral required. 396-1241/436-1272

Gastroenterology—23d of each month, 0730. Appointments limited. Referral required. 436-1173, 396-1351/0341

Internal Medicine—23d of each month, 0730. Referral required. 436-1173, 396-1351/0341

Neurology—16th of each month, 1230. New patients only. Referral required. 396-1351/0341, 436-1173

Nutrition—Appointments available daily, 0730. Referral required. 436-1173

OB/GYN—GYN & PAP Smears—14th of each month, 0730. 396-1351/0341/436-1173 Postpartum & Post Op & OB Registration—Appointments available daily, 0730 (booked one month in advance).

Ophthalmology—Tuesday, 1230 (weekly). Referral required. 436-1272/1173

Optometry—Appointments released on Friday, 0730 (weekly).

Orthopedics—16th of each month, 0730. Referral required. 436-1173/396-1351/0341

Pediatrics—Well Baby—Wednesday, 0730 (weekly). (Booked one week in advance.) 436-1173, 396-1351/0341 Same Day Pediatric Appointments—Call daily at 0730, 396-0349.

Physical Therapy—Appointments available daily, 0730. Referral required. 436-1173, 396-1351/0341

Podiatry—Appointments available daily, 0730. Referral required. 436-1173, 396-1351/0341

Pulmonary Disease Service—23d of each month, 0730. Referral required. 436-1173, 396-1351/0341

Speech Therapy—Thursday, 1230 (weekly). Referral required. 396-1241, 436-1272

Surgical—Breast Clinic Only—26th of each month, 1230. Referral required. 436-1173, 396-1351/0341

Thyroid Scans—Contact Nuclear Medicine—396-9887.

TB—Contact Community Health Nurse—396-7410/5224.

Urology—23d of each month, 1230. New patients. Referral required. 436-1173, 396-1351/0341

Wart—Walk-in daily, except Tuesday, 0730-1000 and 1230-1530.

Appointment release dates which fall on weekends/holidays will open on the next work day. Routine requests for information concerning the hospital/patients should be directed to the Information Desk, 396-3719, rather than Central Appointments.

[From the Town Crier, June 14, 1985]

Medical Emergency Operations Change June 17

(By Alexa Turney)

Discussion of new clinic operation hours highlighted the recent Town Hall Meeting.

Beginning June 17, the Karlsruhe Health Clinic, located at Smiley Barracks, will provide medical services during the hours of 7:30 a.m.-9 p.m., Monday through Friday, and 8-10 a.m., Saturday.

Emergency medical care after-duty hours and on weekends can be obtained at the Karlsruhe Stadtkrankenhaus, Karlsruhe Kinder Klinik (children clinic) or Karlsruhe Stadisches Klinikum. (See maps on this page for location of the German hospitals.)

According to a fact sheet available at the Karlsruhe Health Clinic, residents are encouraged to use the German hospitals only for EMERGENCY purposes during after-duty hours. If an illness or injury can't wait, use the German medical system.

Emergency ambulance service is available by calling the German Red Cross, KC 23332. The Karlsruhe Military Police Station can also assist residents in obtaining an ambulance at KC 759-97. Those calling from outside Karlsruhe should call 0721-23332 for the German Red Cross and 0721-759-97 for the military police.

Also, according to Karlsruhe Health Clinic officials, the military police will be available to distribute handouts and maps and answer questions on proper procedures to follow in obtaining emergency after-duty-hour care. There will be a person at the MP Station who speaks German in cases where a translator is needed.

The German medical officials have been notified that American residents, with after-duty acute illnesses, will be using their facilities, says Maj. Brian Johnson, commander of the Karlsruhe Health Clinic. "They have assured me that their facilities can handle these cases."

For routine medical care during after-duty hours, residents are encouraged to use the 130th Station Hospital in Heidelberg (see map, this page) or to wait, if possible, and use the Karlsruhe Health Clinic during regular-duty hours, say clinic officials.

If residents are unable to use POV's, transportation will be provided by the community. To secure non-emergency transportation to Heidelberg during after-duty hours, call the military police, KC 759-97 for assistance.

Bonafide emergency services provided to active duty servicemembers will be paid for by the U.S. government. All other patients will be billed according to CHAMPUS rules. The patients, not eligible for CHAMPUS, will be billed in full for all services rendered, say clinic officials.

This change in hours of operation at the Karlsruhe Health Clinic will offset the summer physician shortage and eventually, provide enhanced medical services and quality care for community residents, say clinic officials.

Before the change, the Karlsruhe Health Clinic could not offer the best possible service to residents using the facility for after-duty hour emergency care, says 1st Lt. Michael Kotch, executive officer for the clinic. "We may have been misleading residents into believing we offer a fully functional medical emergency clinic (after-duty hours)," says Kotch.

After-duty hours, the clinic had no laboratory, no pharmacy and no X-ray capabilities and minimal medical staff. If a resident went to the clinic after hours with an emergency, the clinic would immediately send them to the German hospital or to Heidelberg. Now, emergencies will go directly to a facility equipped and staffed to handle the situation, says Kotch. "It should be emphazied that now, residents will receive the best available care."

Karlsruhe Health Clinic officials are available during duty hours to answer any questions residents may have concerning the change in operation hours. Residents are encouraged to call KM 8307 or KM 6540 or stop by the clinic. Information packets are also available at the clinic.

Following are some helpful hints provided by the Karlsruhe Health Clinic officials:

German temperature readings are in Celsius. An investment in a Celsius thermometer is recommended, especially for parents with small children.

Teach children and teens how to get medical help in an emergency.

Take full advantage of the German Headstart and Gateway classes available in the community.

Keep important telephone numbers readily available in case of a medical emergency. The German Red Cross telephone number is KC23332; the Military Police Station number is KC 759-97.

Senator WILSON. Thank you, Dr. O'Brien.

Mrs. Day?

STATEMENT OF MARY DAY, VICE PRESIDENT, CITIZENS AGAINST MILITARY INJUSTICE

Ms. DAY. Mr. Chairman, gentlemen, on April 12, 1982, and on April 13, 1983, my husband and I traveled to Washington from our house in Cranston, RI, to tell a Senate Judiciary Subcommittee the story of our 4-year quest to solve the mystery of our son's death in a Navy hospital in 1978. I appear before you today to relate to you the events that lead me to this hearing.

Seven years ago last July, I made a promise. On the day my son, Navy Seaman Charles E. Day was buried, a Navy officer handed me the American flag that covered his coffin. I gave it back. "I love God and I love my country," I told him, "but my country killed my son. I don't know how I am going to prove it, but I am going to prove it."

I am here today because I am still fighting to keep that promise. My son died on July 5, 1978, not in an accident or fighting in a battle, for if he had, I would not be here today. My son died because of medical negligence.

My country killed my son, just as it is killing and injuring thousands of other American servicemen and women by denying them the quality medicial care they deserve. My country is killing its own by continuing to tolerate medical malpractice by members of

the military medical profession who are allowed to hide their mistakes behind the *Feres* doctrine.

Only by allowing active duty servicemen and women and their families the right to sue for negligence will you force the military to accept the responsibility for the malpractice that killed my son and is responsible for thousands of death, and injuries to American servicemen and women. Only by doing away with the *Feres* doctrine will you make the killing stop.

I ask for your support, not only on behalf of my family, but on behalf of the 3,000 families who like us search for the truth about the death of a loved one in the military.

We have banned together in the last 3 years as Citizens Against Military Injustice, to expose the real world of our young servicemen and women: drugs, rape, murder, medical neglect and incompetence and the ever constant threat of reprisal from authority if they dare speak out.

We share another goal. Although our children are dead, we have dedicated ourselves to work for change so that what happened to us won't happen to another mother, father or spouse.

There are thousands of other Americans who support our cause. They have signed our petitions asking the Government for a full investigation of the military medical system and asking our Senators to revoke the *Feres* doctrine.

I appear before you today as their representative. Help us make America's fighting men and women first-class citizens with the same Constitutional rights all Americans enjoy.

My son would have been alive today if someone in the Navy had listened to his call for help. When my son experienced weight loss, vomiting and a fainting episode in May 1978 while on active duty in Naples, Italy, his calls for help were ignored.

He went several times to the base clinic to find out what was wrong with him. Even when he fainted in a barber chair and was rushed to an emergency room, at which time his blood pressure dropped drastically and an irregular heartbeat was noted by a corpsman, still he was ignored. The corpsman looked him over and sent him back to the barracks.

If he had a cardiac workup and he was provided with a halter monitor, the doctors would have learned that he had a serious heart disease. Instead they chose to ignore all these symptoms and advised my son his problems were all in his head.

This statement I found is being used very often in the military health care system. The military corspman decided to send my son back to the States for psychological testing. My son was dying, but it was all in his head.

My son left Italy aboard a Medevac plane on June 26 and arrived at the Naval Regional Medical Center in Philadelphia on June 29, 1978. There he was assigned to the psychiatric ward.

When my husband and I arrived in Philadelphia on June 30, we saw a skeleton of a boy with a yellow tinge to his body. The healthy 5-foot-11, 190-pound boy who left Rhode Island for his first Navy assignment the previous September was no longer there. Instead there stood a boy who now weighed 130 pounds.

The first night in the hospital my son was not given a blanket. He shivered all night with his bathrobe pulled over his head to

keep warm. The next day he was told that he had to participate in ward activities in order to get ward privileges, such as visiting the cafeteria and the hospital PX. They made him play volleyball.

I begged a Navy doctor to test my son's heart. He had never even been given an electrocardiogram, one of the most routine tests. The doctor's excuse was that they were short on staff because of the holiday weekend, which was the 4th of July weekend. He could not order any testing until July 5.

At 4:30 a.m. on July 5, 1978, the corpsman on duty in the psychiatric ward heard my son making snorting noises, but he did not believe my son was having a problem. He though he was having a bad dream.

Incidentally, my son's bed was next to the corpsman's desk.

At 6:30 a.m. a nurse tried to wake my son up. She found him dead.

The first autopsy report listed cause of death Undetermined. It was 5 months later when a second autopsy listed the cause as Probable Fatal Arrythmias. Probable. The Navy still doesn't know the exact cause of my son's death. I believe that they know what killed him, but they refuse to admit it.

Negligence killed my son. The negligence of doctors, nurses and corpsmen who made their minds up about a sick boy without even giving him routine medical tests. The negligence of a country that will spend billions on weapons and bombs, but won't spend enough money to give the men and women who defend our freedom the quality medical care they deserve and that lets the military get away with negligence by letting it hide its mistakes behind the *Feres* doctrine.

There are 11,200 doctors to serve nine million servicemen and women, retirees and dependents.

In 1981 a total of $23 million in undisputed malpractice claims were paid to dependents of servicemen and women. In 1982, $28 million was spent. In 1983, $33 million was spent. In 1984, $41 million was spent.

Wouldn't it be better to spend our tax dollars on medical equipment and to pay our military doctors and nurses the kinds of salaries that will attract the most qualified?

Wouldn't it be better to force the military to admit its mistakes and to accept the consequences?

Instead we and other families must accept the consequences of their mistakes. I hope none of you ever have to answer the phone or open the door and find men in uniform who bring you the news that a son you bore and raised and loved won't be coming home.

Someday I would like to accept the flag I gave back to the Navy the day I buried my son. I love my country, but I will only accept the flag when I know that another parent or a wife will not have their son, daughter, or husband come home in a casket like my son did.

Only when I know that our servicemen and women are no longer second-class citizens, but first-class ones, treated with respect and dignity, only when I am assured that servicemen and women, retirees and dependents are receiving the quality medical care they deserve, only when the *Feres* doctrine no longer shields medical neglect will I accept the flag.

At this time I would like to submit to this committee the plight of other families who are members of CAMI. Our servicemen and women and their dependents need your help. Please help them, for you only have the power.

Thank you.

[The testimony of CAMI members follows:]

TESTIMONY OF CITIZENS AGAINST MILITARY INJUSTICE

OCTOBER 8, 1985

SUBMITTED BY CITIZENS AGAINST MILITARY INJUSTICE
MEDICAL ISSUES COMMITTEE

National Headquaters
P.O. Box 7072
Hampton, Va. 23666

Medical Issues Committee
293 Webster Ave.
Cranston, R.I. 02909

INTRODUCTION

IT WAS THE INTENTION OF THE MEDICAL ISSUES COMMITTEE OF THE CITIZENS AGAINST MILITARY INJUSTICE (CAMI) TO COMPILE SUMMARIES OF ALL CASES, BROUGHT TO CAMI'S ATTENTION, WHERE IMPROPER OR NEGLIGENT HEALTH CARE IS ALLEGED TO HAVE OCCURED IN DEPARTMENT OF DEFENSE (D.O.D.) FACILITIES. LIMITED RESOURCES AND THE PROMPT SCHEDULING OF THESE HEARINGS PRELUDED AN ATTEMPT TO COMPILE A COMPLETE RECORD AT THIS TIME.

INCLUDED HERE ARE SELECTED CASE SUMMARIES, PREPARED BY VICTIMS OR THEIR SURVIVING NEXT OF KIN, WHICH WE BELIEVE REPRESENTS A SYSTEMATIC FAILURE OF APPROPRIATE MILITARY AUTHORITIES TO RESPOND TO LEGITIMATE INQUIRIES OR GRIEVANCES ABOUT MEDICAL AUTHORITIES TO RESPOND TO LEGITIMATE INQUIRIES OR GRIEVANCES ABOUT MEDICAL CARE RECEIVED. MANY OF THESE SERVICE MEMBERS HAVE MADE EXTRAORDINARY EFFORTS TO ALERT MILITARY AUTHORITIES OF PROBLEMS ENCOUNTERED WITH MILITARY HEALTH CARE ONLY TO BE INGNORED OR SHUNNED. MANY WHO EXPERIENCE SEVERE INJURY OR INCAPACITATING ILLNESS QUICKLY UNDERWENT A CHANGE OF STATUS FROM ACTIVE DUTY TO TEMPORARILY DISABLE RETIREMENT (TDRL) OR EVEN MEDICALLY DISCHARGED TO A VETERANS ADMINISTRATION HOSPITAL BUT ENDURED DELAYS BEFORE PAY AND BENEFITS WERE ACCORDINGLY ADJUSTED CAUSING SEVERE EMOTIONAL AND FINACIAL DURESS FOR THEM AND THEIR FAMILIES. SOME SOUGHT RELIEF OR RECOURSE IN THE COURTS ONLY TO HAVE THEIR CASE DISMISSED, WITHOUT HEARING AND A DETERMINATION OF ITS MERIT, BECAUSE OF A JUDICAL TENET CALLED THE FERES DOCTRINE. OTHERS SOUGHT ASSISTANCE THROUGH CONGRESSIONAL OFFICES AND LEARNED THAT EVEN SINCERE, EMPATHETIC STAFF HAVE LIMITED INFLUENCE OVER D.O.D. WHEN A QUESTION OF MEDICAL CARE IS INVOLVED.

WE SUGGEST : THAT BEFORE THIS COMMITTEE ACCEPTS D.O.D. ASSERTIONS THAT THE QUALITY OF HEALTH CARE IN THE MILITARY IS EQUAL TO THAT IN THE CIVILIAN COMMUNITY, IT ASK HOW CAN SUCH A BOASTFUL CLAIM BE MADE WHEN MECHANISMS FOR CONSIDERING INDIVIDUAL COMPLAINTS ABOUT MILITARY MEDICAL CARE ARE WOEFULLY INADEQUATED. CAMI WOULD LIKE THE MEMBERS OF THIS COMMITTEE TO BE PARTICULARLY ATTENTIVE TO THESE COMMON COMPLAINTS.

1.) *Failure of medical corps or other non - pysician providers of health care to consult pysicians when a service members systems persist or worsens.*

2.) *Failure of D.O.D. pysicians to consult appropriate medical specialties, to support the seeking of a second opinion, to prompt transfer to facilities more skilled in certain types of medical care when, for example, diagnoses of heart disease, cancer, or a rare disease are made.*

3.) *Failure by the Command or Casualty Assistance office in question to promptly notify next of kin when injury or illness is severe or persistent.*

4.) *Failure by the Health Care Personnel to answer inquiries by service members patients or their families during illness or following an unexpected death.*

5.) Failure of military authorities to release complete medical records in a timely manner

6.) Failure of military authorities to complete all required paperwork so that pay and compensation are uninterrupted when a service member is placed on TDRL or medically discharged.

7.) CAMI is aware of an alarming number of complaints by service members who either are denied proper access to psychiatric services or allege improper and unduly prolonged confinement in pyschiatric units; who allege maltreatment and the administration of drugs, some experimental, without their consent while involuntarily confined, and who are, perhaps least, able to to have their grievance heard or record cleared, once labelled with a psychiatric illness.

IT IS BEYOND THE RESOURCES AND CAPABILITIES OF CAMI TO DEMONSTRATE WHETHER THE COMPLAINTS DESCRIBED HEREIN ARE BONAFIDE INSTANCE OF MEDICAL MALPRACTICE OR THE UNJUST DENIAL OF A SERVICE MEMBER'S CIVIL RIGHTS. WHAT DISTURBS US, NO D.O.D. OFFICE, AND NO ARM OF THE SENATE EXISTS TO HEAR OUT THESE COMPLAINTS WHEN THEY ARE NOT RESOLVED AT THE LEVEL OF THE LOCAL COMMAND. MOREOVER, WE DO NOT EXPECT THE SENATE TO REVIEW EACH COMPLAINT ON A CASE BY CASE BASIS IN ORDER TO PROVIDE INDIVIDUAL RELIEF. WE ASK ONLY THAT FUTURE ALLEGATIONS OF MEDICAL MALPRATICE BE ALLOWED ADJUDICATION IN A FEDERAL COURT BECAUSE, WE BELIEVE THIRTY-FIVE YEARS OF OPERATION UNDER THE BLANKET OF IMMUNITY CONFERRED BY THE SUPREME COURT FERES DECISION, HAS MADE THE MILITARY HEALTH COMPLEX ARROGANTLY INSENSITIVE TO CRITICISM, SLOW TO KEEP UP WITH STANDARDS IN THE CIVILIAN COMMUNITY, AND BLIND TO ITS OWN MISTAKES AND SHORTCOMINGS. WE BELIEVE THESE HEARINGS WILL HELP RID INCOMPETENCE FROM MILITARY HEALTH CARE, REGARDLESS TO WHAT DEGREE IT EXISTS, AND WHETHER IT IS MORE OR LESS THAN IN THE CIVILIAN SECTOR: WILL INDUCE A CONSTANT TRIVING TO IMPROVE STANDARDS: AND AFFORD THOES WHO DO PROVIDE QUALITY HEALTH CARE IN THE MILITARY, A MORE RESPONSIVE AND PROGRESSIVE SYSTEM WITHIN WHICH TO WORK.

WE THANK ALL THE MEMBERS OF THIS COMMITTEE FOR THE KIND INVITATION TO SUBMIT TESTIMONY ON BEHALF OF ALL MEMBERS OF CAMI WHO HAVE BEEN INJURED OR DIED AS A RESULT OF NEGLIGENCE IN MILITARY HOSPITALS, IN THE UNITED STATES AND OVERSEAS. WE TRUST THAT AFTER A THOROUGH EXAMINATION OF THE ISSUES INVOLVED DURING THESE PUBLIC HEARINGS, THIS COMMITTEE WILL FIND THE FERES DOCTRINE PROTECTION HINDERS THE ASSURANCE OF QUALITY HEALTH CARE IN THE MILITARY AND THAT BY ALLOWING MEN AND WOMEN WHO SERVE OUR COUNTRY IN THE ARMED FORCES THE BASIC RIGHT OF JUDICIAL RELIEF IN INSTANCES OF MEDICAL MALPRATICE, STANDARDS OF HEALTH CARE WILL IMPROVE AND CONFIDENCE AND DISCIPLINE IN THE MILITARY SYSTEM WILL STRENGTHENED.

WE THE CITIZENS AGAINST MILITARY INJUSTICE, ASK YOU TO SUPPORT SENATOR SASSER'S BILL SENATE BILL S-489.

We would also like to make you aware of our findings; Undisputed dependents awards for medical malpractice.

1981--- $23 million
1982---$29 million
1983---$31 million
1984---$41 million

Hospitals---168 U.S. Military Hospitals, including 130 in continental United States
Docters----13,704 docters, 12,670 are on active duty, the other 1,034 are civilians.
Patients---Average outpatients visit is 15,000 per day. The average outpatient visit is 50 million per year.
Beneficiaries---The total number of potential beneficiars are,
10.2 million, 5.7 million on active duty, and their dependents and 4.5 million retirees and their dependents.

When 29,000 mothers to be were wheeled into the delivery room at a Air Force hospital in 1982, they expected the pains of labor, but for some the suffering lasted much longer. They went home reconering from severe cuts and tears that occurred at a rate of twice the national average.

In 1982 24 docters figured they had found a smart way to beat the recession. Scheduled for work at a military hospital, they instead chose to see patients on goverment time at a civilian hospital miles away. They took a pay check from both.

Heart attacks or heart related deaths to 1,393 active duty personnel in 1982-83 were all under the age of 26 years old. Can all these young people die of heart problems????

AGAIN THANK YOU FOR THE INVITATION.

CITIZENS AGAINST MILITARY INJUSTICE
MEDICAL ISSUES COMMITTEE
CHAIR; MARY DAY (R.I. CAMI)
DR. ROBERT GUIDMOND (MASS. CAMI)
TIFFANY HALL,RN. (NC. CAMI)
CAROL TOURTELLOTTEE, RN. (CONN. CAMI)
JOAN HOOVER RN. (MASS. CAMI
DR. WILLIAM Q. STURNER (R.I. CAMI)

SERVICE MEMBER: TSgt. Albert Branch, Jr., U.S. Air Force
Died March 20, 1984

MILITARY HEALTH FACILITY: Navy Branch Medical Clinic at
Moffett Field Naval Air Station, CA

FAMILY ADDRESS: Linda F. Branch (wife)
Albert Branch, III, and Stephanie Branch (Children)

Florida
(904) 763-5046

FACTS & CIRCUMSTANCES: Air Force TSgt. Albert Branch, Jr. was stationed at Air Force Station Sunnyvale, CA in March, 1984 when he went to the Navy Branch Medical Clinic at nearby Moffett Field Naval Air Station with severe stomach pains and nausea. His condition was diagnosed as the flu. He was not admitted to the hospital and collapsed and died at home the next morning. The Dept. of Legal Medicine, Armed Forces Institute of Pathology reviewed TSGT Branch's medical records and concluded that the diagnostic assessment fell below the standard of care required in an emergency room. In addition, the physician who examined Branch failed to get a second opinion as requested by his wife.

RESPONSE OF MILITARY AUTHORITIES: Mrs. Branch has received no assurances that the type of negligence and inexperience which contributed to her husband's death will be avoided in the future.

SUMMARY PREPARED BY: Joan M. Hoover, RN, CCRN
July 1985

SERVICE MEMBER: Seaman Jerry Meagher, U.S. Navy (Ret.)

MILITARY HEALTH FACILITY: Naval Regional Medical Center, San Diego

CURRENT ADDRESS: Jerry Meagher
Dorothy & Frank (Parents)
569 Buena Vista Place
Bisbee, Arizona 85603
(602) 432-3751

)

FACTS & CIRCUMSTANCES: On Jan. 17, 1974 Jerry Meagher checked into Balboa Naval Hospital to have a small cyst, benign, removed from his left arm. On the morning of Jan. 18 he was administered three nerve blocks in a 70 minute period and 15 mg. of Morphine IV over 10 minutes. During this time his complaints of chest pain went unheeded and he suffered a cardio-pulmonary arrest. After transfer to a recovery room, not an ICU, he suffered a second arrest to which the trauma team did not respond for two hours. Today Jerry is a guadrapelgic and unable to talk. He lives at home with his parents where he has recently learned to write some messages.

RESPONSE OF MILITARY AUTHORITIES: Inquiries by Jerry's parents as to what happened, why the trauma team was not called immediately, and what happened to the medical personnel involved, have never been answered by the Army Medical Command. In 1977 the Supreme Court denied a hearing on the Meagher's suit, citing the Feres Doctrine. Jerry's former Congressman, James McNulty, Jr., introduced H.R. 1942 in the 98th Congress (now H.R. 1161 in the 99th Congress) to allow active duty service members to sue the military for medical malpractice. Although, this legislation, if enacted, will not be retroactive and be of direct benefit to Jerry, Dorothy Meagher has promised her son she would dedicate the rest of her life to remove the unjust judicial tenet, the Feres Doctrine, from our legal system. She contends that Jerry, who intended to go to law school after his discharge from the Navy, would want this. Jerry currently receives a veterans disability check for about $3,500 which falls $1,000-$1,500 short of expenses for his full-time round-the-clock care at home. Periodically, Jerry's parents must appeal cutbacks in VA benefits for Home Health Care and other efforts to discourage them from keeping Jerry at home. In a VA hospital, Jerry nearly died due to a severe failure to thrive.

SUMMARY PREPARED BY: Joan M. Hoover, RN, CCRN
June 1985

SERVICE MEMBER: Stephen W. Briggs, Airman First Class, USAF (deceased), 035-40-6442

MILITARY HEALTH FACILITY (S): Tripler Army Medical Center, Hawaii
Hickman AFB Clinic, Hawaii

PARENTS: William & Charlotte Briggs
78 Stamford Ave.
Providence, RI 02907
(401) 785-9813

FACTS & CIRCUMSTANCES: AFC Stephen W. Briggs died on or about 3/15/82 in temporary lodging quarters on Hickman AFB in Hawaii. Parents were not advised as to the cause of death until 8/82, after, repeatedly, calling the Air Force Casualty Center seeking this information. The autopsy report was received by the parents in 10/82. It stated cause of death was aspiration of blood due to an upper gastrointestinal bleed. No reason was given for this internal bleeding.

RESPONSE OF MILITARY AUTHORITIES: We received numerous letters and documents which contain conflicting accounts of the facts and circumstances surrounding the death of our son. An obvious attempt to cover up the facts by certain individuals is evident. There is definite misrepresentation of autopsy findings by Tripler Army Medical Center and the Armed Forces Institute of Pathology (AFIP). Tripler Army Medical Center delayed sending pathological materials to the AFIP. Family later received an apology for this delay. The AFIP performed a slipshod review of the autopsy report and withheld, for a time, certain pathological material from Dr. William Q. Sturner, a civilian Medical Examiner in RI, who we asked to independently review our son's case. We have been continually distressed by the arrogance and ignorance presented in correspondence received from the Chief of the Rheumatology Clinic at Tripler Army Medical Center. This individual should know more about the case than anyone else, but claims he has no knowledge of certain facts which are readily available to him.

SUMMARY PREPARED BY: William A. Briggs, Jr.
Charlotte A. Briggs
June 1985

SERVICE MEMBER: MAJOR General Billy B. Forsman, USAF
Director of Intellegence for European Command
until his death, Nov. 15, 1981

MILITARY HEALTH FACILITIES: USAF Hospital, Wiesbaden, Germany
Wilford Hall, Texas
Malcolm Grow Hospital, Andrews AFB

WIFE"S ADDRESS: Doreen M. Forsman
3019 Cunningham Dr.
Alexandria, VA 22309
(703) 780-3554

FACTS & CIRCUMSTANCES: Service Medical Personnel, including the Chiefs of Neurology at the Wiesbaden USAF Hospital, improperly diagnosed General Forsman's back pain as due to back stress and later "two dead nerves in the back" over an eleven month period from March 1980 to Jan. 1981. General Forsman checked himself into the hospital in Germany and vowed not to leave until his physicians found out what was wrong with him. A sonogram revealed a massive tumor surrounding his right kidney and xrays showed metastase to both lungs. Following surgery for removal of the tumorous kidney, he was sent to Wilford Hall, Texas supposedly for a three week course of radiation treatment before returning to active duty. After arrival at Wilford Hall, he was told he would be medically retired within three weeks and when he questioned these orders he was then informed he had less than six months to live. General Forsman learned, from the Director of Cancer Research at San Antonio, that five weeks after he was first examined in Wiesbaden he had an abnormal urinalysis and one physician recommended an immediate IVP exam. Later, his physican at Malcolm Grow Hospital told him his medical records had been removed by the Surgeon General without her approval and that he was ordering Chemotherapy treatments she did not agree with. When she question these orders, she was threatened with court martial by the Surgeon General. Despite efforts to obtain records sooner, General Forsman did not have access to his medical records until nine days before he died.

RESPONSE OF MILITARY AUTHORITIES: Mrs. Forsman inquired about the results of investigations by the Office of the Surgeon General, USAF; the Office of the Air Force Inspector General; and the Department of Legal Medicine, at the Armed Force Institute of Pathology (AFIP). A physician at the AFIP privately claimed the doctors at Wiesbaden "barely provided minimal care and should have done an IVP based on an urinalysis report done on an early visit", however all investigation reports deny improper care or that any cover-up was initiated. In fact they suggest General Forsman's complaints resulted from delusions caused by hypercalcemia resulting from his tumor. General Forsman asked that Doreen fight for his right to sue for negligent care. She has pledged to do so and to force the Air Force to retract claims her husband suffered from psychological changes.

SUMMARY PREPARED BY: Doreen M. Forsman
June 1985

SERVICE MEMBER: Navy Seaman Charles (Chuck) E.Day, Jr.
Died July 5, 1978

MILITARY HEALTH FACILITY: Philadelphia Naval Hospital

PARENTS ADDRESS: Mary & Charles Day
293 Webster Ave.
Cranston, RI 02909
(409) 943-5165

FACTS & CIRCUMSTANCES: In Feb., 1978, six months after he enlisted and after being stationed in Naples, Italy, Chuck Day began vomiting after meals. By May, 1978 he had an irregular heart beat, had weight loss, and a critically low blood pressure which was observed by personnel at a military dispensery. He underwent a Gastro-intestinal series of xray exams but was referred to a Naval psychologist. At this time, his mother attempted, through Senator Claiborne Pell's office, to have him transferred home for medical treatment but was unable to do so. The vomiting and weight loss continued and he was admitted to a psychiatric ward at the Philadelphia Naval Hospital on June 27, 1978. A few days later, after she visited her son, Mary Day demanded he have xrays and an electrocardiogram to evaluate his irregular heart beat but was told there was a staff shortage. Within the week, a medical corpsman noted snorting sounds from Chuck's room but failed to do anything and Chuck was found dead 45 minutes later.

RESPONSE OF THE MILITARY AUTHORITIES: The initial autopsy report along with reports from the Navy Bureau of Medicine and Surgery and the Naval Surgeon General requested by Senator Pell gave no answers about why Seaman Day died. At the request of the Day family, Dr. William Q. Sturner, RI Chief Medical Examiner, reviewed the Armed Forces Institute of Pathology reports and determined that Chuck Day received improper care on two occasions: 5 months after he enlisted he complained of depression but was not referred to a psychiatrist and later when he exhibited fainting spells, a low blood pressure, and cardiac arrythmia, he should have seen a cardiologist. The autopsy report said the immediate cause of death was fatal cardiac arrythmia secondary to fibro-muscular proliferation of intramural coronary arteries. Mrs. Day has never been able to learn what type of work her son did in Italy and whether it contributed to his heart disease. An attorney advised the Day family that even an air tight case of medical malpractice could not get pass the Feres Doctrine in court. Both Senator Pell and Chafee of RI have supported a Private Bill to allow the Days to bring suit but the Chairs of both the Senate and Armed Services Committees oppose all private relief. Mary Day has pledged to prevent such negligence from occurring to another mother's son and has worked diligently to amend the Federal Tort Claims Act to allow active duty personnel the right to sue for medical malpractice.

SUMMARY PREPARED BY:

SERVICE MEMBER: ML. FA. Jeffery L. Sellers, U.S. Navy
Died May 22, 1980

MILITARY HEALTH FACILITY: Sick Bay aboard U.S. L.Y. Spear (As36)

PARENTS ADDRESS: Judy & Marvin Sellers
4544 Bellevue Road
Onondaga, MI 49264
(517) 628-3564

FACTS & CIRCUMSTANCES: After requesting two investigations into our son's death, we learned he had died from medical neglect. The last investigation admitted the medical care he received was below what Naval standards should tolerate. This was stated by the Fleet Surgeon. We pursued our son's case in court but it was dismissed. One of the deciding factors in the case was the Feres Doctrine.

RESPONSE OF MILITARY AUTHORITIES: We had to request a second investigation to get the Navy to admit medical neglect. The first report stated he got the best possible medical care which the second report showed to be untrue. We still don't know the true cause of death as of this date, five years later. We were given only a probable cause. A lot of our questions and complaints were never fully addressed.

SUMMARY PREPARED BY: Judy & Marvin Sellers
June 1985

SERVICE MEMBER: Ms. Denise Chaffee Soltys, U.S. Army (Ret.)

MILITARY HEALTH FACILITY: Nobel Army Hospital, Fort McClellan, Alabama, 8 August 1979.

CURRENT ADDRESS: Denise and Paul Soltys
57 Longview Drive
Florence, MA 01060
(413) 584-2543

FACTS & CIRCUMSTANCES: While in her fourth week of basic training, Ms. Denise Chaffee Soltys was admitted to Nobel Military Hospital, Ft. McClellan, Alabama, on 25 July 1979 for the purpose of undergoing medical tests and treatment for abdominal pains and amenorrhea. On 8 August 1979 she underwent a routine operative procedure known as dilation and curettage (D&C) with exploratory laparoscopy to ascertain the nature of her pains and associated difficulties. Due to the negligence of the attending medical staff, Ms. Chaffee Solty's oxygen supply was some how impaired, either in the course of the operation or during recovery. As a consequence of the lack of oxygen, Ms. Chaffee Soltys suffers from diffuse post anoxic encephalopathy, a severe and irreversible brain pathology, resulting in a number of physical dysfunctions. She remained in a comatose state, completely paralyzed, blind, unable to care for herself, and could not speak audibly for months. Ms. Chaffee has spent a substantial amount of time over the past six years in various VA hospitals undergoing therapy and treatment for a host of recurring ailments. As a consequence of her permanent brain damage, she is legally blind and nystagmic, her speech is dysarthric, she has an unsteady gait, and is unable to do fine movements with her hands. Moreover, she continues to have episodes of severe headaches frequently followed by uncontrollable epileptic seizures.

RESPONSE OF MILITARY AUTHORITIES: Notwithstanding numerous requests, the Army has NEVER formally responded or provided an official explanation as to the specific causes of her injuries. Ms. Soltys filed an administrative claim against the Department of the Army. In its response, the Army not only rejected her claim but categorically refused to investigate the accident, callously stating:

> "In view of the decision above, no investigation has been conducted by this Service into the alleged malpractice and no opinion is expressed in the matter."

Additionally, it took over a year and a half of wrangling to obtain the complete medical records, portions of which are hardly legible. In the course of the latter effort, Ms Soltys was told that the records were destroyed in a fire, were lost, were elsewhere, etc. Only persistence and an inordinate amount of inconvenience resulted in the ultimate production of the medical records. Her case was taken to the Federal Court where her final appeal was ultimately rejected by the Supreme Court of the United States on 17 October 1983. The basis of the rejection was the Feres Doctrine. To this day, Ms. Soltys' questions have never been answered!

SUMMARY PREPARED BY: Dr. Robert Guimond, Attorney for Denise C. Soltys
June 1985

SERVICE MEMBER: TMSN David Lawrence Dann, USN, Submarine Squadron 8, Died Sept. 14, 1982

MILITARY HEALTH FACILITY(S): Medical Corpsman, Subtender, Norfolk, VA
Naval Regional Medical Center, Portsmouth, V
McGuire Veterans Hospital, Richmond, VA

PARENTS ADDRESS: Donald & Daphne Dann
9925 Mango St.
Houston, TX 77075
(713) 944-5854

FACTS & CIRCUMSTANCES: David was ill on the U.S.S. Baton Rouge for six weeks. the Medic told him "he did not have any symptoms that warrented his seeing a physician". He never examined David. After he started vomiting and became visible bloated, he was sent to the Naval Hospital in Portsmouth. We were told by Dr. Sears, LCDR/MC, that David ahd a severely enlarged heart, irreversibly damaged due to a long delay before treatment. At Portsmouth he was placed in a ward, not an ICU. Seven days later he was medically discharged, transferred to the McGuire VA, and placed in a roach infested "isolation" room. Although David's EKG showed a severe heart block and arrythmia, he was never evaluated for a pacemaker. Several months later, David was discharged with no advice to restrict physical activity and little information about his heart medications which were marked "no refill". He went two days without his heart medications, returned to the VA in severe distress, placed in a ward without a heart monitor where he died of a cardiac arrest.

RESPONSE OF MILITARY AUTHORITIES: It took nearly a year before I could get medical records from the Navy and the VA Hospitals. Through the efforts of the American Legion, we received most of them. An inquiry was made by the offices of Senator Tower and Congressman Ron Paul. They received identical replies, "The treatment that David Dann received was medically sound and appropriate". Regarding the care given on the sub and sub tender, "treatment aboard ship and while hospitalized at the Naval Regional Medical Center, were adequate and appropriate". The President of CAMI in South Texas wrote J.J. Quinn, Commodore, Medical Corps with specific questions and complaints about David's medical care but received a carbon copy of the response supplied our Congressman. Our family has never received correspondence directly from the Navy.

SUMMARY PREPARED BY: Daphne & Don Dann
June 1985

SERVICE MEMBER: Germaine Marie Braden, Specialist Four, U.S. Army, 405-25-4598
Died Nov. 2, 1983

MILITARY HEALTH FACILITIES: U.S. Army Hospital, Wurezburg, Federal Republic of Germany; and the Landstuhl Army Regional Medical Center, Landstuhl, FRG

PARENTS ADDRESS: Sergeant Major and Mrs. J.W. Braden
620 Sanota Drive
Anniston, Alabama 36206
(205) 820-6239

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FACTS & CIRCUMSTANCES: Diagnosedas having a viral syndrome, the physician refused hospitalization stating, "I can't hospitalize her for a cold". Our daughter's treatment sheet stated the upper respiratory system was CLEAR. The physician returned her to the FIELD on a clear liquid diet where she had to sleep in an improperly heated tent with eating and sanitary facilities a good distance away. At this time she was experiencing symptoms of vomiting, diarrhea, and needed assistance to walk yet she was returned to a remote site with no cooks, no medics, and no one instructed to see to her needs. Our daughter was found dead, four days later, severely decomposed. LARMC, autopsy performed by a PFC. Extraction and incineration of internal remains violated page 4-1 of Army Regulation 638-40. (quote by PFC Flores, "I threw them in the garbage can".) All testimony can be obtained from LTG Thompson, the Department of the Army Investigating General.

RESPONSE OF THE MILITARY AUTHORITIES: We had no problems obtaining a copy of the Inspector General (IG) investigation, however the conclusions are totally biased, incomplete, and unacceptable to us. The I.O.'s used very selected extractions from testimony to support a view favorable to the Army. The DAIG, LTG. Thompson, MAJ. Newman, and Mrs. Campbell of the DOD IG have agreed with the conclusions of the I.O.s, however all three stated they have NOT READ THE WHOLE REPORT. An expert statement, obtained by us from a civilian medical authority, showing that Dr. Szela did not provide proper care was refused by the I.O.s. Dr. Szela was cleared by using only military medical experts who were furnished with selected extractions from testimonies and with some incomplete information. The estimated date and time of death was based in part on unreliable testimony of SGT Ward who we believed lied. Despite contrary evidence, the I.O.s accepted her testimony. The UNAUTHORIZED removal and disgusting and horrible treatment of our daughter's internal remains was not addressed by the IG.

SUMMARY PREPARED BY: Sergeant Major and Mrs. J.W. Braden
June 1985

SERVICE MEMBER: EMFN Michael P. Smith, USN, 207-54-8267
Died June 23, 1984

MILITARY HEALTH FACILITIES: Sick bay, Frigate Davidson
Sick Bay, USS Kitty Hawk

PARENTS ADDRESS: Irene and John Smith
1562 Summit Ave.
Linwood, PA 19061

FACTS & CIRCUMSTANCES: EMFN Smith was sick for two weeks with a cough and wheezing before officially permitted bedrest aboard the USS Davidson. A paramedic on the Frigate Davidson thought he was faking it according to a legal deposition taken by Naval investigators. For four days he lay in his bunk too weak to care for himself. The paramedic made a diagnosis of bronchitis and later pneumonia but prescribed only pain relievers and cough medicine and never conferred with a physician accessible by radiocommunication. Four days after Smith registered a 104° temperature, he was transferred off the Davidson to the Aircraft Carrier, the Kitty Hawk where he was examined by Physicians who doubted he would live but did not hasten his transfer to a hospital. Four additional days passed before Smith was lifted by helicopter to a Hospital in Fremantle, Australia. He died the next day. His family was not informed of his condition until just before he died. His body was poorly taken care of after his death and his remains were barely viewable.

RESPONSE OF MILITARY AUTHORITIES: The Hospital Corpsman, Michael A. Stofan who cared for Smith was issued a punitive letter of reprimand, fined $1,000, and denied re-enlistment. Stofan has an additional two years of service to complete and has been re-assigned to the Naval Hospital at Bethesda, MD. The Lt. Commander of the USS Davidson and Smith's Division Officer, Lt JG Schmidt were both issued letters of reprimand. Corpsman Stofan blames the Navy for not providing him with opportunities to continue his education and for having no experience taking care of severely ill patients yet being Chief Hospital Corpsman. The Smith family is upset with the decision of Vice Admiral David R. Harlow to assign Stofan to duty as a Corpsman, even if he will not be working independantly.

SUMMARY PREPARED BY: Joan M. Hoover, RN, CCRN

SERVICE MEMBER: SP.5 Larry Carter, U.S. Army, 585-60-6351
Deceased

MILITARY HEALTH FACILITY: William Beaumont Army Medical Center
Fort Bliss, TX

WIFE'S ADDRESS: Shirley Carter
Oakwood Tr. Ct. #31
Waynesville, MO 65583
(314) 336-3274

FACTS & CIRCUMSTANCES: My husband died of an intra-cranial infection secondary to five brain surgeries and placement of VP (Ventral-Peritoneal) Shunt. I believe my husband received negligent care by his physician who would not see my husband when he was on call and who other physicians stated he had a severe drinking problem. These statements were obtained through legal deposition. I believe the VP shunt was not properly turned on and that he was not properly taken care of in other ways so that I took care of him most of the time while he was a patient at the Army Medical Center.

RESPONSE OF MILITARY AUTHORITIES: Any information I have found has been on my own initiative. The Army has offered no assistance. I have tried for over 3 years to get the findings of the IG complaint and to this day have never seen the report. Now, I have been informed it has been destroyed. Because of the Feres Doctrine, my claim for compensation was turned down. I'm expected to simply accept this and this, for me, is impossible. Since all this happened, the physician in question has been promoted. I'm told that he has recovered now from his alcoholism but what about all the damage he did before? Peoples lives, my life, has been ruined.

SUMMARY PREPARED BY: Shirley G. Carter
June 1985

SERVICE MEMBER: ETSN Timothy White, U.S. Navy
Died July 1984

MILITARY HEALTH FACILITIES: Sick Bay, Naval Training Center, Orlando, FL
Medical Personnel aboard the destroyer ship, Mahan, and at the Base Hospital, Naval Station, Charleston, S.C.

MOTHER'S ADDRESS: Lois Presley

, Florida

FACTS & CIRCUMSTANCES: Medical records show a mole which Timothy reported was changing color and enlarging on the back of his neck was not noted on his enlistment physical, Sept. 19, 1980 as he reported. His records indicate medical personnel noted a change Feb. 5, 1981 but recommended no excision. In December, 1982 Timothy again reported his concern about the mole's enlargement to Nurses and a staff Otolaryngologist who repaired a deviated septum on a surgical admission at the Medical Clinic at the Charlestown Naval Hospital. In April, 1983, over 2 years after first reporting the mole to Navy medical personnel, it was biopsied at the Dermatology Clinic at Charlestown. Timothy was diagnosed with malignant melanoma. On June 3, 1983 he was determined unfit for duty and accepted Temporary Disability Retirement. After radical neck surgery and much delayed radiation treatments, he died in a VA Hospital in Birmingham, Alabama.

RESPONSE OF MILITARY AUTHORITIES: Timothy White received his disability payments in Feb., 1984, almost one full year after applying for them and only after inquiries by Congressman Tom Bevill's office in Gadsden, Alabama. Chase Untermeyer, Assistant Secretary of the Navy for Manpower and Reserve Affairs, in a letter to Timothy's mother said preliminary reports showed several medical personnel failed to identify and promptly treat the cancer but that the Department of the Navy has not decided if any individual was "so culpable as to merit discplinary or adverse administrative action". Naval officials in Washington told Mrs. Presley she had no legal right to her son's medical records.

SUMMARY PREPARED BY: Joan M. Hoover, RN, CCRN

SERVICE MEMBER: James E. Olson, Cpl., U.S. Marine Corps

MILITARY HEALTH FACILITY: Denied access to a physician, hospital.

MOTHER'S ADDRESS: Marilyn Makelky
1811 Allison Dr. #8
Bismarck, N.D.

FACTS & CIRCUMSTANCES: James died of malaria Nov. 9, 1980. He was aboard the ship, USS Frederick, bringing the Marines back to Hawaii after an Indian Ocean tour. James was ill for a week but was not seen by a doctor until his death. A request by a medical corpsman that a doctor be sent by helicopter, from the nearby ship, the USS New Orleans, was ignored. James was given only asprin during the week he was severely ill. The written requests by the corpsman were balled up and thrown away, and several times he radioed the New Orleans only to be turned down.

RESPONSE OF MILITARY AUTHORITIES: I did not have any difficulties getting the facts of my son's death or his illness prior to that. They admitted there was negligence.

SUMMARY PREPARED BY: Marilyn Makelky
June 1985

SERVICE MEMBER: Robert Lee Dean, Jr., ET3 Petty Officer, USN

MILITARY HEALTH FACILITIES: Nuclear Power School Training Center and Naval Hospital in Orlando, FL

PARENTS ADDRESS: Marion Dean
42254 Parkside #101
Sterling Heights, MI 48078

FACTS & CIRCUMSTANCES: We saw our son die, slowly, over a period of 7 months. He began to lose weight in May of 1984. He lost 70 pounds in those months, dropping from 205 lbs. to 135 lbs. at the time of his death. He nosebleeds, reported to Navy Medical personnel in May during a stay in the hospital. When he was home on leave, he told me his nose had been cauterized which helped some but the Navy now denies he had this procedure. He lost hair in December, 1984. When he was home in Dec., we noticed he part his hair differently to hide his hair loss. He developed severe constipation sometimes going for weeks without a bowel movement. He was reporting to the hospital during this entire time and received enemas and laxatives which did not relieve the problem. We saw our son for the last time on Jan. 1, 1985 when he left forOrlando. He weighed 142 lbs. when he left our house. A physical was done on my son on Jan. 28, 1985 reporting his weight loss yet he was not hospitalized.According to the first autopsy report done by a Medical Examiner in Orlando, my son died in his sleep Jan. 31, 1985. His body was exhumed after 2 months and a second autopsy report done by Werner Sputy of Michigan showed a severe bowel impactment. The first report concluded death from coronary-pulmonary arrest due to anorexia.

RESPONSE OF MILITARY AUTHORITIES: A 815 JAG Report told us nothing but contradictory statements and repeated errors. Captain Greenman called and told us he didn't know why my son wasn't taken care off. My son received a complete military funeral with color guards and an 18 gun salute. We think the Navy feels responsible for our son's death but they refuse to give us the true story. That is all we are asking for so that we can sleep at night. We know our son suffered the last night of his death. In our hearts we suspect he was exposed to either ionized radiation or some toxic chemicals. We are at a standstill with no answers from the Navy.

SUMMARY PREPARED BY: Marion Dean
June 1985

SERVICE MEMBER: Seaman Apprentice E2 Jack Achabowski, USN
Disabled since July 1976

MILITARY HEALTH FACILITIES: USS Wainwright
Sub Tender, Charlestown Naval Hospital,
S. C.

ADDRESS: Kathy and Jack Achtabowski
4276 Hollow Corners Road
Dryden, MI 48428
(313) 796-3311

FACTS & CIRCUMSTANCES: During the summer of 1975, I was assigned to a paint detail aboard the USS Wainright and was ordered to sand and paint in non-ventilated areas. We were required to use ship's fuel which contained benzene to clean up with. After one month of this duty, I became ill with fatique, nosebleeds, and petchiae. The physcian at the Charlestown Naval Hospital recommended I not continue this work but I was not taken off this duty. My conditioned worsened and from Jan., 1976 to July, 1976 I was hospitalized with a diagnosis of idiopathic thrombocytopenia, a severe deficiency of platelets which means I am subject to spontaneous episodes of bleeding and need steriod therapy. In July, 1976 I was placed on TDRL for five years. In August, 1981 I was medically discharged at 60% despite being unemployable due to the high risk and unpredictable nature of my blood disorder. I filed suit in a Federal Circuit Court against the Military for failure to provide safe working conditions, failure to diagnosis a severe illness resulting from these conditions. The Judge expressed empathy for my situation and held onto my case until a recent Supreme Court decision regarding Feres was decided. Feres was upheld, so the Judge "regretfully" suggested I withdraw my suit rather than have it denied outright.

RESPONSE of MILITARY AUTHORITIES: I do not understand why Medical Personnel did not assist me further to get off duty which was hazardous to my health. It took a full year before the paperwork was straightened out and I received my benefits once my status was changed to TDRL.

SUMMARY PREPARED BY: Jack Achtabowski
July 1985

SERVICE MEMBER: Major David J. Brown, U.S. Army, Infantry,
Foreign Area Officer until disabled
May 22, 1980

MILITARY HEALTH FACILITY: Womack Army Hospital, Fort Bragg, NC 28307

WIFE's ADDRESS: Mrs. Truc N. Brown
6813 Woodstream Dr.
Seabrook, MD 20706
(301) 794-5780

FACTS & CIRCUMSTANCES: My husband, David J. Brown, went in for minor surgery called a varicoselectomy. He was at age 36 intelligent, healthy, and strong. Following surgery he was comatose for 8 days with brain stem damage. He is now totally and permanently disabled and depends on 6 different kinds of anticonvulsant drugs to control his seizures. My husband is an only child and I take care of him in my home. He volunteered in the Army for the love of his country.

RESPONSE OF MILITARY AUTHORITIES: The Medical staff kept my husband at Womack for nearly 2 months and denied him a chance to get the best available rehabilitation program. The medical doctors involved either received cash bonuses or got promoted a few months after turning my husband into a human vegetable. The IG report, given me, was inconclusive. I feel I was subject to harassments by the military personnel at Womack Army Hospital.

SUMMARY PREPARED BY: Mrs. Truc N. Brown
June 1985

SERVICE MEMBER: Anthony Dewayne Valentine, L/CPL, USMC, 031-52-1595
Deceased

MILITARY HEALTH FACILITIES: Sick Bay, USS Peleliu
Sick Bay, USS Cleveland

PARENTS ADDRESS: Mrs.Freedie Jean Valentine
M-14 Algonquin Terrace
Plymouth, MA 02360
(617) 747-3691

FACTS & CIRCUMSTANCES: My son died of pneumonia while on active duty. I have tried to get Anthony's medical records and have been unable to do so even through Congressional Offices. I have spoken with several lawyers, none of whom will handle the case because of the Feres Doctrine.

RESPONSE OF MILITARY AUTHORITIES: We received many conflicting reports and confusing information from the Marine Corps. Often we got the run around by rude and insensitive marine personnel. An autopsy was not performed as requested. It was a prolonged time before our son's remains were returned to us from Japan. We still do not know the facts and circumstances surrounding his death.

SUMMARY PREPARED BY: Mrs. Freedie Jean Valentine
June 1985

In Memory

Our son, Kevin Douglas Kimball, was a normal, healthy, 21 year old college student in May of 1981. He suddenly became ill complaining of fever and bloody diarrhea so he went to our family practice physician at Fort Belvoir Dewitt Army Hospital. Kevin was told he had a virus and when on the following day he was worse, he again went to the same doctor. He was seen by the doctor but advised to return home and to return to the clinic after the Memorial Day weekend. On Tuesday, he returned to the hospital and at this time he was admitted since he obviously was no better and appeared quite ill. During this first week of hospitalization he received no medication and no diagnosis was made. An x-ray was scheduled for the following week. This x-ray, which should have been done days before, showed a toxic mega colon and ulcerative colitis which is a medical emergency situation. Medication was started although we were told later that this medication was not the correct type - and x-rays were done daily of his colon. All this time Kevin was losing blood. On Friday, the situation became even more critical and an operation was performed by the Chief Surgeon. After spending the weekend in ICU, Kevin appeared to be doing well and was returned to the surgical floor and mostly under the care of a resident. After having no solid food for over two weeks, Kevin was put on a regular diet rather than a bland diet. Kevin started to vomit every time he ate or drank and continued to lose weight. Before becoming ill, he weighed 165. We were quite concerned about this nausea and vomiting but were not given any explantion or show of concern by the staff. Although a daily input and output had been ordered, the nurses were not doing this and their nursing notes were either not done or very erratic about his care. Blood work done this week showed infection but nothing was done about this nor were we informed. All medication had been stopped 3 days after the operation. No one seemed to know much about the care of an ileostomy and even the surgeon admitted afterwards that it was only the 2nd time he had performed that operation. Surgery had been done on June 5th and on June 14th Kevin developed respiratory distress and went into shock. He was taken to ICU late that night and died early on the morning of June 15th. Even the life saving measures tried at this time were not done properly.

After an autopsy and having Kevin's hospital records carefully gone over by medical experts, we were to learn that his care was at fault from the day of admittance to the time of death. There was no communication between the staff of nurses and doctors regarding his daily lack of progress and they literally allowed him to lie there and die. At death, he weighed 123½. Because of this, we filed a claim against the government hoping to change the methods of "care". This took 3 years before settling out of court. As far as we know, all personnel involved are still practicing. The Chief Surgeon told Kevin the day before he died that it was "all in his head"--- but now it is all in my heart.

Nancy Kimball, Kevin's mother

On July 30, 1982, Senior Airman, Brian K. Davis died. Had he lived to November 21st of that year he would have been 22 years of age.

His situation, was not a unique one, we have learned since his death. He was stationed at MacDill A.F.B. in Tampa Florida, and that base has a track record for errors that are extraordinary.

We, his parents, have to this date been fighting the battle of super secrecy and lack of communication imposed by the military, in incidents where questionable judgement has been used.

The afternoon of Friday, July 30, 1982, our son Brian, came home (un-announced), and informed his mother, the hospital had released him. I was working nights, at the time. I spoke briefly to him, over the telephone. My wife told me, he seemed very nervous and tense. He had something to eat, then decided to visit his brother in Melbourne, Florida, some 25 miles south of our home. The next morning, he was to go onto a prearranged camping trip in the Ocala National Forest, with his buddies and co-workers at the base hospital, his duties where EMC. Saturday morning some 12 hours later, a military group came to our home, informing us, our son Brian had taken his life.

Our contention always has been, he was prematurely released from the hospital, while still not fully recovered from his illness.

Brian's past medical History included a brief admission to USAF Regional Hospital, MacDill, on May 20, 1981. He was then air-evaced to USAF Regional Hospital, Eglin A.F.B., for inpatient psychiatric evaluation on May 22nd, 1981 and returned to duty sometime in June 1981.

After his return to MacDill A.F.B. on July 1, 1981 he was seen by a Captain Tartasky, with a follow up on October 30, 1981. He during this period of time was treated with supportive therapy, and no psychotropic medications. Brian was again admitted to USAF Regional Hospital at MacDill A.F.B. on July 26, 1982. Under the diagnosis of mental exhaustion, and for psychiatric observation.

With the knowledge and past history known by the MacDill A.F.B. hospital Doctors/ "Psychiatrists", coupled with the fact we were both seen by his Doctor and told at that time (July 28, 1982), that Brian appeared Hypersensitive and nervous. They would be running some tests and make a final determination on Brian's case, later that week.

Our feeling is: these medical/mental Doctors and or Technicians made a grave mistake, by allowing our son off base, while he was obviously still in need of medical survillance, for his own well being.

In addition to this unresolved tragic situation, we had too, at the time of Brian's death suffer under the additional emotional stress, of constant military induced delays, uniform and equipment mixups, and losses, and an added burden thrown in by the Veterans Administration. While making arrangements for Brian's interment at our pre-selected grave site, we were informed by a V.A. Representative, Brian could not be placed in Long Island National Cemetary, next to his sisters, instead would have to be interred some 50 miles away at Calverton National Cemetary. Our persistance and with the help of a local Congress mans secretary, we were able , some six months later to go through the trauma and expense of another trip to Long Island New York, and had our son re-interred at Long Island National Cemetary.

We are still hopefull, that somehow the military will re-examine those "medical" professionals decision to prematurely release our son from the hospital. All the other indignities and set backs, we will just have to learn to live with.

Joan and Richard Davis
245 Coldstream Avenue
Merritt Island, Florida 32953

We are sorry but due to lack of space this story had to be shortened.

Aracelis Turull-Santiago
13000 S.W. 256 Terrace
Homestead, Florida 33032

July 31, 1985

Mary Day
293 Webster Avenue
Cranton, Rhode Island 02909

Dear Ms. Day:

I had a son, Juan Heriberto Bonilla-Santiago, who was a proud American, so much, that he served his country for more than 7 years. Now I ask "For What"!. You see my son Johnny was murdered by the Navy doctors. Doctors that he trusted but did not care for him or the pain his family is going through and will have to live with for the rest of their life. The so called "Doctor" that are not qualified to take care of a dog, and are put to work in a place where human beings go to, to seek medical help, "Doctors" that have no medical knowledge or diploma, "Doctors" that just don't care.

Johnny's full name and rank is; MMFN Juan Heriberto Bonilla-Santiago SS# 581-04-4809 born July 16, 1957, died December 15, 1984 at Balboa Naval Hospital. Death Certificate - cause of death: (See Attached)

1. Acute respiratory failure - hours
2. Diabetic Ketoacidosis - 5 days
3. Diabetes Mellitus - unknown

The above is the military's report on cause of death; but on December 3, 1984, my son had a pimple on his face, he went to the Naval Hospital and was given an antibiotic by Dr. Jam Talley 246-4143 - 120; Erythromycin 250 mg. 2 x a day. By December 10, 1984 he was experiencing some discomfort in his stomach. On Tuesday December 12, 1984 he went to the Naval Medical Clinic, San Diego, but it was so crowded and he decided to go back to his girl friend's house. On Wednesday, December 12, 1984, he went back to the Navy Medical Clinic and was seen by Dr. Rodriguez and was given a prescription for Kaopectate - Licocaine - Benadsus to gargle as directed by doctor, for mouth sores and #20 Acetaminophen 325 mg. to take 2 tablets every 4 hours. That night his girl friend - Aida Rodriguez gave him the medicine as directed by the doctor. On Thursday, December 13, 1984, he started to vomit and he kept complaining of a burning sensation in his stomach. He could not eat, so his girl friend Aida called Dr. Rodriguez and told him that Johnny was still sick and that his vomiting had continued. Dr. Rodriguez told her that all he

had was a stomach virus, and to give him lots of juice, jello and lots of love. Dr. Rodriguez stated that what he was feeling was normal for a stomach virus and he was to get plenty of rest, stay in bed and gave him 2 days off from duty.

On Friday, December 14, 1984, his condition had worsened and at 7:30 a.m. he went to the hospital. His girlfriend called Dr. Rodriguez the hospital to check on his condition at about 12:00 p.m. Dr. Rodriguez told her that Johnny was still at the hospital and he was administering the third bottle of an I.V., that Johnny should be home around 1:00 p.m. Dr. Rodriguez assured Aida that Johnny would be okey after that. Dr. Rodriguez gave him another prescription of Prochlorperazine 5 mg., 1 tablet every 6 to 8 hours as needed due to the severe dehydration.

Johnny went to this friends house, Carlos Vazquez, who lived near the clinic, just in case he felt worst his friend could take him there fast. When Carlos got home, at approximately 9:30 p.m. he saw how sick Johnny was, and called, National City Paramedic. When they arrived they checked him and gave him oxygen because he was having shortness of breath. They asked Carlos if Johnny was a <u>diabetic</u>; when Carlos asked Johnny, his answer was "no" because he had not been diagnosed as a diabetic. The Paramedics then told Carlos to take him to the hospital. Carlos wanted to take him to a civilian hospital, but Johnny wanted to go to the Navy hospital. Carlos was able to put him in the car and drive him to Balboa Naval hospital. Once in the hospital the attendants there <u>did not</u> act as they were supposed to, for no one bothered to come and check him right away. Five minutes later a doctor came, Johnny by this time was scared and told Carlos. Carlos spoke to the doctor in charge and the doctor told him "<u>he will be alright</u>" and asked Carlos to leave, with the promise to go and pick him up in the morning. From there, the doctors took over and gave their own covered-up version of what happened.

At 11:30 a.m. Florida time on Saturday, December 15, 1984, Dr. LCDR McGuire called my home to tell us that our Johnny had died at 6:30 a.m. that morning.

My question is; are these the kind of doctors that are taking care of these men and women who have given their lives and youth, their freedom to be with their families to defend a country as great as ours, only to have them look at them without any regards for their lives and the ones they leave behind. I ask myself; who has given them the right to play "God" and waste a life to that so precious to the ones who love them.

What kind of government do we have? we are so willing to help other countries, spend money going to space, spend money on war heads, but are not concerned in giving adequate treatment to heal or at least <u>"TRY"</u> to give these men and women the treatment they so well deserve.

My son was **NEVER** given a blood or urine test. If they had, I would have had my Johnny come home by the end of June beginning of July after serving his country for more than 7 years. Now, all I have is memories of my son and the hurt of knowing that he was killed, not by a car accident or by another person but by the Navy doctors, doctors that he trusted and failed him. Then the pain of having to wait five (5) days for my son's body to arrive home, because there was no space available. I ask myself where is the justice, and I ask Johnny was it worth your life, to give **IT TO A COUNTRY WHO IS SO CALLUS WITH HUMAN LIVES!**

I only hope that my letter like thousands of others that have written will start the ball rolling to elimnating the injustice of our government against our people. Maybe it won't hurt so much knowing that somethings can stop the injustices and carelessness.

It has been almost eight months that my son was murdered, I am still waiting for his complete medical report. All I have received are letters from the Judge Advocate General asking me to wait. **FOR HOW MUCH LONGER? WHAT IS TAKING SO MUCH TIME?** His records were there so why must go on waiting?

Yours truly,

Aracelis T. Santiago

ARACELIS T. SANTIAGO
MOTHER

5 Riverview Road
Gloucester, Mass. 01930
Tele: 617-283-6363

Citizens Against Military Injustice
p.o. Box 7072
Hampton, Virginia 23666

To whom it may concern:

I am writing with urgent need of help from your organization. My twenty year old daughter, Sp. 4 Jennifer L. Williams has been subjected to one medical error after another along with being the victim of a multitude of judgemental errors. Jennifer and I both have copies of documentation that will confirm this, yet it has been passed off lightly while her severe medical problem, service related, has continued. The problem has existed for two years now, and because of a medical crisis in Korea, which had gone untreated, with the possibility of death occuring, my husband and I contacted Congressman Nicholas Mavroules and Senator Kennedy, both of Massachusetts. They arranged an emergency medical air evacuation to Walter Reed AMC. The soldier in concern, Jennifer Williams, has been the subject of apparently, unethical medical practice. It appears that she is being denied her military and humanistic rights. Her constitutional rights have been violated and this entire situation has become a game of cover-up at Jennifer's expense. My husband and I went to Walter Reed AMC to see Jennifer and it was made quite clear to us that the Army is angry because we have launched a congressional investigation on behalf of our daughter. As a result of this, Jennifer has become a victim instead of a patient. It is quite evident that we are now in a "cat and mouse game", a test of wills, or better yet, who has "Power" and who doesn't.

I can only tell you, at this time, WE NEED HELP! The entire situation has become a haulicaustic nightmare and is totally out of hand. I have much information available and I am in desparate need to convey to you the atrocities going on at Walter Reed AMC concerning Sp 4 Jennifer Williams. Our time is running out; I need to make contact with your organization immediately; I can provide the details of the situation, and forward written info later, if needed. As I stated, we need assistance immediately. Please telephone me if possible so that I could better explain the existing situation and problem. We truly need, at this time, somebody to intervene and stop the tactics

and brutality that is taking place against this young soldier before any further damage is done to her.

Most respectfully,

Mr. & Mrs. Merrill R. Newman, Jr.
5 Riverview Road
Gloucester, Mass. 01930
Tele; 617-283-6363

56-614 O—86——10

19 June 85

To Whom it may Concern:

My name is Jennifer Lynn-Williams, SSN 027-50-6380. I am a Specialist Fourth Class in the United States Army, active duty.

I strongly believe that my Military and Humanitic Rights have been and are being infringed upon. I have documents of my Medical and Military history. Although, right now, time is of the essence. Therefore, I would be more than willing to give all necessary information at a later date.

Since Basic Training, February 1983, I have had recurrent pain, swelling and coldness in both lower extremities. I have continuously sought medical attention. I have received no medical care until my parents contacted Congressman Mavroules, at which time my physical condition reached a crisis point and I was Medevaced from Korea to Walter Reed Army Medical Center, Washington, D.C. I have been an inpatient here at Walter Reed on Ward 7A since 29 May 1985.

It has become quite apparent that the Medical Staff here is angry with the fact that there is a Congressional Investigation in progress. Yet, the investigation has nothing to do with Walter Reed AMC or its Staff.

Since my admission, I have been

tested but not treated.

I have been told by my physician, Doctor Steinweg, that Medical Board proceedings will soon be initiated. The Medical Board is all administrative, yet I have been denied convalescent leave for no reason. This is my third hospitalization since March. I have had no convalescent leave a time off. Now that all testing has been completed and a decision has been made, I feel I rightly deserve a standard 30 day convalescent period.

Once I am discharged, I will be placed in Medical Holding Company. At that time I will no longer be eligible for convalescent leave. I need some help. I believe that intervention now is mandatory.

I ask that you contact my parents with any information you can offer. Their name and address is: Patti + Merrill Newman
5 Riverview Rd
Gloucester, Ma 01930
617-283-6363

Thank you for your time. My parents and I will be anxiously awaiting any assistance you can give.

Yours Respectfully,
SGT Jennifer L. Williams

July 1, 1985

Military Injustice
P. O. Box 7072
Hampton, VA 23666

On June 8, 1984 I was seen at the GYN clinic at Ireland Army Hospital, Ft. Knox, KY for an annual pap smear at which time also a pelvic exam was given. At that time I requested treatment for menopausal problems which I did not receive. Due to my disappointment with the service I received, I made an appointment with a gynecologist in Louisville on July 27, 1984. An adnexal mass, 5-6 cm in size, was detected. Surgery took place Sept. 24, 1984. The delay for the surgery was due to the run-around I received from Ft. Knox in either getting a commitment from them for surgery, which they were going to schedule in Oct. but they changed their minds later, or a non-availability slip which I received in Sept. The verdict after surgery was CANCER.

This is just a brief description of events. I have copies of the pathologist's report and other medical records in my possession. Also, I took notes of events as they occurred.

Can you be of assistance in recommending the best attorney for legal advice and representation in case of a suit? Is there other help available for victims like myself? I need all the assistance I can possibly receive, it's been a rough year.

My husband is retired from the military. We have been married 35 years of which 22 years were on active duty.

I will be very greatful for any assistance you could provide.

Sincerely,

Ursula B. Eckstein

Ursula B. Eckstein
11111 Oliverda Drivez
Valley Station, KY 40272
(502) 937-9715

1520 University #205
Albuquerque, NM 97102
26 July 1985

Good day,

A recent article in my local newspaper alerted me that all is not lost. I commend you for your action and efforts. I want to lend you my support.

Enclosed is an article printed by the Enlisted Times, a small independent newspaper in San Francisco regarding me and my specific military medical malpratice problems.

Please let me know if I can be of assistance to your organization.

Sincerely,

Catherine Carol Williams

Catherine Carol Williams
Phone # (505) 342-9306

Senators, This is only one of many problems that exist for women in the Military, Fort Dix, in Kentucky is the worse.
" A frequent saying among female soldiers (at Fort Dix) was, "Don't get sick below the waist."

Presidio of San Francisco and Wuerzburg, Germany

Woman GI gets the military medical shuffle in U.S. Army Europe

After being arrested for AWOL while sitting in a hospital waiting room and afterwards being admitted to three different psychiatric wards, Sp/4 Catherine Carl (Ce Ce) Williams, 33, finally received the medical treatment she desperately had sought for two years.

By Gail Stewart
Staff Reporter

"It was a nightmare," Williams said in reference to her numerous attempts to receive adequate medical attention from the Army.

When she arrived in the Spring of 1977 at her first permanent duty station, Fort Dix, N.J., a frequent saying among female soldiers was "Don't get sick below the waist," as it was rumored the gynecology (GYN) facilities there might open be closed down.

At Fort Dix, Williams, as a personnel action specialist, handled [illegible] frustrated enlistment cases. About six months into the job, she began having severe pelvic pain as well as abnormal loss of blood during her menstrual period.

She went on sick call, but was given only pills to kill the pain and stop the excessive bleeding.

Around January 1978, Williams was transferred to Wuerzburg, Germany. During that time, she became depressed because the pain became so intense and the bleeding so severe. She went to a military general practitioner who prescribed Valium and suggested she "jog" for her depression. He did not give her a physical examination.

"He kept saying there was nothing wrong with me," Williams said. Williams claims it took her 11 months to even see a gynecologist.

The Army gynecologist performed a D&C (dilation curettage, a procedure which dilates the cervix to permit the scraping of the walls of the uterus). Williams said the two told upon "nothing is wrong."

If the gynecologist had performed an ultra-sound study on her uterus and ovaries, he would have noticed adhesions on the uterus from a Cesarean as well as cystic structures on the ovaries, Williams claimed. The study, usually performed to search for tumors, uses high frequency sound waves that [illegible] "She said, 'pray out.'"

However, "the pain mounts after the D&C, the pain and bleeding get worse," Williams said.

Williams appealed to her supervising NCO for help, but received none, she claimed. "He didn't want to be bothered. He never even tried to do anything," Williams said. Her unit commander at the regional personnel center where she was last sent her, "You're doing a good job. Keep up the work," Williams responded. "He didn't want to hear what I was saying." Williams said.

Realizing no help would be forthcoming, Williams came home on leave to Long Beach, Calif., in January 1978.

"Approximately Group office to drop up her "AWOL status."

Later, while sitting in the Appropriations office, the clerk called the hospital to verify whether or not Williams would be admitted and was told they (the Navy) had an obligation of keeping her because she was under Army control.

A surgeon in the office told Williams to report back to the office the next morning and to begin travel to go back to Germany. Instead, the "Good" surgeon accompanied by her mother, she went to the Long Beach Community Hospital where a doctor in emergency examined her and said she was "not fit to travel." The doctor said that because she was on AWOL [illegible]

Sp/4 Catherine Carol Williams at Letterman Army Medical Center in San Francisco in Discharge.

A frequent saying among female soldiers (at Fort Dix) was, "Don't get sick below the waist."

[illegible] instructed Williams to go back to the Navy Hospital.

A couple of hours later, while sitting in the Navy Hospital's GYN waiting room clinic, two armed MPs came in, put handcuffs on her and placed her under arrest for AWOL.

Ironically, at Wuerzburg, Williams was in charge of [illegible] servicemember on court-martial charges. She had undergone a tubal ligation in 1973.

After Williams returned from [illegible] she appealed her Article 15 punishment to regain her rank and retroactive pay.

However, Williams claims her paperwork remained untouched for three weeks in the Presidio S.F. IAG office, although submitted the appeal, with her reasons for being [illegible] AWOL, to her commanding officer (C.O.).

While waiting for a response from her C.O., Williams wrote her congressional representative.

Williams' representative sent an inquiry to the Department of the Army regarding her experience and requested the Army's position on Williams' case.

The Army, in turn, replied that Williams had been "provided appropriate medical care," and that her arrest and subsequent trip back to Germany was "most unfortunate."

Williams claims the representative "put pressure where pressure was needed."

Soon, the Inspector General's office at Williams' duty station intervened and subsequently her C.O. granted the appeal. Williams regained her rank and received retroactive pay.

A Presidio Public Affairs spokesman said Williams' C.O. had "reviewed the case and decided the punishment was too severe."

Williams, whose enlistment ends in June 1980, said she is very bitter about what she considers the gross medical neglect on the part of the Army that kept her in unnecessary pain for two years.

Said she, "I'm tired of fighting with the military."

[illegible] Navy Hospital, Williams was [illegible] to the Long Beach City Jail, where [illegible] medical staff examined her, she was searched, fingerprinted, photographed and put in a cell. The following morning MPs put her on a plane to Germany.

Upon arrival in Frankfurt, Germany, Williams requested to be taken to the Army Hospital and had herself admitted to the Psychiatric Ward.

"I was going crazy. I knew there was something wrong with me despite what the Army doctors said. I became suicidal at this point," Williams said.

While on the psych ward Williams said, "I felt like I was on trial every morning at 9 o'clock." Every day all the patients in the ward had to endure questioning from three psychiatrists and the nursing staff, she recalled. "They were treating my mind instead of my body," Williams said.

Again, she was examined by another Army doctor who told her "there was nothing physically wrong" with her, Williams said. "He interrogated me since I was a patient on the psych ward. I had to be imagining the pain," she said.

One week later, Williams said she was escorted back to her unit in Wuerzburg and booted from Specialist Four to Private First Class and put on total restriction for two weeks for her three-day AWOL.

The drug was [illegible] Williams said, the [illegible] "barely get a spoon" to her mouth, so on her own she cut the dosage in half. "Even then I was bombed most of the time," said Williams.

Williams said the contact help from a chaplain at the Wuerzburg Hospital. He petitioned for her to be medically evacuated to Letterman Army Medical Center (LAMC) in San Francisco, Calif.

Upon arrival at LAMC in April 1979, Williams was admitted to the Psychiatric Ward. A military doctor in the GYN clinic examined her and an ultra-sound study was done. The soon-to-be-transferred doctor suggested she undergo a hysterectomy. No follow-up was done.

In June, Williams' personnel [illegible] to examine the [illegible] she might be hemorrhaging and went to the Emergency Room, where she was referred to the GYN clinic. Finally, Williams said, two LAMC doctors examined her and agreed a hysterectomy would be necessary. Several weeks later Williams underwent surgery.

Williams had a long history of pelvic and uterus problems, and to avoid the risk of cancer developing in her uterus, she had wanted a hysterectomy (partial or full removal of the uterus). Because her [illegible]

July 18, 1985

C.A.M.I
Mary Day,
293 Webster Ave.,
Cranston, Rhode Island 02909

Our son, Bruce Edward Wahl, #557-82-9690, now deceased, went into the Air Force a healthy boy and was discharged 6 years later a sick man. I want to know why he was refused medical care. I want answers. I feel I am entitled to them.

He told us he had been exposed to Agent Orange at Johnson Island. After he became ill, rash and skin peeling, military doctors gave him prednisone and parafon forte to relieve the skin problem. One doctor told him that he had damage to the adrenal glands because too much prednisone had been given and that he would only live a few years, due to this problem.

We feel his illness was military related. The V. A. refused to see the boy when we took him to the Clinic in Sacramento, saying they did not take responsibility for agent orange cases. They also refuse to pay a substantial amount on the funeral bill. We have incurred some expenses during the last few months of his life and we feel we should be reimbursed.

May we have some answers. We feel our son was a casualty. Our peace of mind is something to be considered.

Sincerely,

H. E. WAHL
P. O. Box 47
Chico, Calif. 95927

Senator WILSON. Thank you, Mrs. Day.
Dr. Skillicorn?

STATEMENT OF S.A. SKILLICORN, M.D., DIRECTOR OF MEDICAL AFFAIRS, SAN JOSE HOSPITAL, SAN JOSE, CA

Dr. SKILLICORN. Thank you.

I appreciate the invitation to appear before the subcommittee. I have submitted a statement which is comprehensive. I would like to paraphrase some of my views for the sake of time.

I want to make it quite clear I appear as an individual. I do not represent any medical organization in my testimony. My remarks reflect my personal experience devoted over the past decade, or so, to quality assurance in hospitals.

I picked up the inference this morning in the discussion about health services in the military that at least implicitly all goes well in the civilian sector. I am here to testify that all does not go well in the civilian sector.

The quality of civilian medical care in the United States, in my opinion, is not nearly as good as it should be. Even the widely publicized clinical calamaties and horror stories that occasionally break through the heavy curtain of concealment surrounding the health care industry do not reflect the extent of the problem.

Something must be done to improve the situation. I have found that is not easily accomplished because most health professionals are reluctant to admit there are serious deficiencies in the health care delivery systems, particularly in hospitals, where our sickest patients are treated.

Hospital leaders prefer to dwell on the good things that happen in American medicine today. When they do face up to the problem of impaired quality, they tend to look for scapegoats.

There is a growing conviction that the solution for substandard medical care is simple, that all we need to do is to identify those physicians who are clinically, physically or mentally incompetent, and remove them from the health care system.

I wish it were that simple. There is no question that tougher licensing credentialling and peer review procedures for physicians need to be instituted in order to weed out the incompetents.

However, it is my opinion that incompetent physicians represent just the tip of the iceberg of inadequate quality controls. Bad doctors account for a very small percentage of the total spectrum of breakdowns in the quality of patient care. As a matter of fact, more often than not it is our very best physicians who are involved in patient care tragedies. So, why does substandard care exist?

Well, my experience has been that most medical mishaps occur because of inefficiencies in the internal systems of care, particularly in hospitals. With the growing complexities of medical and surgical treatments in the past two decades professionals have become increasingly dependent on those systems of care.

Unfortunately, many of those systems are obsolete and inadequate. They are in need of drastic revision. Let me describe one example.

Currently it is being recommended that mortality and morbidity rates, that is death and complication rates, be established as a

prime method for the measurement of performances of individual physicians and of hospitals. The belief is that the profiles will reflect the level of the quality of care.

There is even talk of installing a national data bank of physicians' mortality and morbidity profiles that can be evaluated.

Obviously, monitoring of deaths and complications is important, but it is after the fact. By the time incompetent physicians are identified, patients have suffered serious damage. I am personally very uncomfortable with the knowledge that as a patient I may involuntarily become a statistic in a mortality data bank that eventually demonstrates I got there because my physician and my hospital were incompetent.

Perhaps the retrospective information will be of benefit to future patients, but I would prefer to contribute to their well-being in some manner other than self-sacrifice. Seriously, that is the way the present review system works. It is always after the fact.

To my mind, there is an urgent need to establish concurrent reviews of health care professional activities. That is, we need methods to measure performances while they are happening. We must find ways to prevent bad outcomes through stricter surveillance of the processes of care, not just identify and evaluate adverse events after they have occurred.

Our traditional practice of "learning from our mistakes" is simply too hazardous for patients. We have got to find better ways to measure quality.

It is my conviction that the revision of our medical delivery systems can be accomplished more expeditiously in the armed services than in the civilian sector. The military has the organizational advantage of operating under a structure of authority that is lacking in civilian hospitals.

Resistances to change in the highly competitive civilian health care system are so intense that the modifications that will be necessary to favorably impact the quality of patient care are not likely to occur in the near future. It is going to take a significant change in economic incentives to turn the civilian system around.

The incentives presently do not encourage the provision of quality care. The military medical services have the unique opportunity to become a model for quality health care in our Nation. All they need is the commitment, the determination, and the support to do so. I sincerely hope that the armed services will accept the challenge.

Thank you.

[The prepared statement of Dr. Skillicorn follows:]

Prepared Statement by S.A. Skillicorn, M.D.

A career change more than a decade ago placed me in an opportune position to devote full time and energies to hospital quality assurance work, including evaluations of numerous American hospitals. The experience has allowed me to formulate some personal observations and opinions regarding the current status of quality controls of health care.

The care of patients in American hospitals in large part is good, but it is not nearly good enough. The mission of hospitals is to provide and facilitate quality health services. Unfortunately, they have forsaken much of that responsibility. Things happen to patients that should not happen. Sometimes they are terrible things that occur because operational budgets, building programs, external regulations, exciting new technology, and other activities of survival and expansion receive more attention than does the basic quality of care.

This poor order of priorities is causing hospitals and physicians to lose control of their own destinies. Various external forces are starting to move into their territories to accomplish what they have failed to do. The growing malpractice crisis has upset them. They have deluded themselves into believing that a lawsuit-hungry public and overzealous attorneys are primarily responsible for their plights. They are wrong. Lack of adequate quality controls is why troublesome events occur in hospitals. There are far more episodes of malpractice occurring without the attendant filing of a liability claim than there are occurrences where claims are filed. The public is beginning to recognize that fact. So long as hospitals, their medical staffs, and their governing boards continue to treat the quality of patient care casually and so long as the public becomes more knowledgeable and plaintiff attorneys become smarter, things are going to get worse. The malpractice crisis will be turned around only when malpractice is curtailed. It is for physicians and hospitals to accomplish this task by significantly improving the quality of care that they render.

Mishaps in hospitals do not occur under complicated or sophisticated circumstances. They usually result from simple oversights, absent-mindedness, or neglect. Most of the breakdowns occur because of patient care performance deficiencies, not because of a lack of knowledge or training. Busy professionals become involved with other duties, they are interrupted or easily distracted, or they become nonchalant in their work. They begin to believe that mistakes are inevitible, and they treat them as expected risks of being hospitalized. When such an attitude takes over, people begin to make even more errors.

Although the majority of patient care mistakes are due to errors in the performances of individuals, the professionals making the errors usually do so because of inadequacies in the hospital systems. Some of the systems even appear to have been designed to allow or to encourage breakdowns. There is a paucity of check and double check practices. The situation will not improve until those systems are revised. But comfortable traditions and long-standing occupational behavior habits are so dominant in hospitals, that proposed changes often meet with much skepticism and resistance.

Physicians play a major role in the management of patients. Yet the system used to determine the competency of physicians in the hospital setting has some serious deficiencies. The focus is predominantly crisis oriented and punitive directed rather than problem oriented and preventive directed. Almost all peer reviews of physicians' performances are retrospective rather than concurrent evaluations. Some adversity has to happen before review takes place.

Because physicians are in authoritative positions, most of the mandated patient care evaluation regulations have been directed toward them. However, it is important to recognize that they have minimal personal involvement in the 24-hour care of hospitalized patients. The majority of care is provided by other professionals who are under the supervision of hospital management. Evaluation of performances logically should be applied to all other professionals as comprehensively as it is to physicians. But evaluation systems under hospital management are frequently inadequate, and the evaluations that do take place tend to be highly subjective and lacking in uniformity.

Management attitudes are influenced significantly by external pressures. Numerous governmental regulations and detailed standards developed by the Joint Commission on Accreditation of Hospitals have been imposed upon hospitals to keep them functioning at least at a basic level. Unfortunately, hospitals become smug once they have met those mandated standards, and a minimum-requirement mentality pervades the institutions. Some hospitals even resent the enforcement of the minimum standards. Improvement of quality controls will not occur until hospitals increase their commitments to quality assurance programs and until minimum-requirement attitudes are overcome.

The Joint Commission on Accreditation of Hospitals in 1980 published new standards for quality assurance, and over the past few years there has been considerable pressure exerted to ensure hospital compliance. The standards represent a good start, but much more needs to be done. The foundation has been laid for taking a really important step in quality assurance beyond the passive, ritualistic, retrospective methods of today's patient care evaluations. Death chart reviews, a traditional form of peer review, are of some benefit in helping us learn from our mistakes, but they have virtually no

value to the patients who have died as a result of medical error. A more dynamic, system-oriented and problem-oriented approach is needed with concurrent and prospective reviews that evaluate situations while they are happening, if not before they happen.

Earlier this year I had the opportunity to make a rather thorough evaluation of the quality assurance program of a large military hospital. It is an excellent program that compares favorably with most civilian hospitals that I have visited. Recently I participated in a Department of Defense Health Council Conference in which I became familiar with the quality assurance policy directives which the DoD Health Affairs has promulgated over the past three years as well as future quality assurance activities planned by DoD Health Affairs. I am impressed by the obvious commitment of William Mayer, M.D. to improve the quality of health care in military medicine. I believe he has made an excellent start in the right direction. The task that lies ahead is formidable.

Although my knowledge about the present status of the quality of medical care in the military is limited, I am convinced from what I have learned recently that health care problems in the Armed Services are probably not significantly different from those that exist in the civilian system. Unfortunately, the shortcomings in the military sector have been receiving considerably more publicity than have those that occur regularly in civilian hospitals.

In my opinion, the Armed Services are in a far better position to improve the quality of American health services than are their civilian counterparts.

Improving the quality of care in hospitals, whether they are civilian or military, will not be easily accomplished. Lifelong patterns of professional behavior will have to be changed. Coveted inner sanctums of patient care will have to be invaded and the mystique of their functions erased. Peer review, especially physician peer review, will have to become more comprehensive and much more aggressive. There are serious matters about the preservation of confidentiality that have to be worked out. There are also important financial considerations that will have to be addressed--quality is never cheap.

Indeed, it is going to be very difficult. Nevertheless, it has to happen. It is no longer a matter of choice; it is a matter of necessity. Quality controls must remain as the "conscience" of all health care systems.

Stanley A. Skillicorn

Stanley A. Skillicorn, M.D.
Director of Medical Affairs
San Jose Hospital
San Jose, California

October 1, 1985

Senator WILSON. Thank you very much, Dr. Skillicorn.

Dr. O'Brien, it appears that the results of the survey that your organization conducted came pretty close to the results of the survey conducted by the Department of Defense.

The one complaint that interestingly seems to be absent from both of those surveys is the poor quality of care, at least in the sense that we have been previously discussing that.

In other words, there has been considerable focus today on malpractice, on negligence, and properly so. Your survey, as well as that of DOD, clearly identified a level of service that you think would be inadequate, and I thought very instructive, was your recital of the schedule.

Dr. O'BRIEN. I have a whole page of that in the written testimony.

Senator WILSON. The question that arises from that commonality between your survey and that of the Department of Defense is whether or not you think that the quality of care being received by your members, if we can distinguish that from a level of service, is, by and large, adequate notwithstanding the existence of obvious malpractice on certain occasions.

Dr. O'BRIEN. It has been our observation that the quality of care in the military system is as good as, if not better than, that in the civilian sector. The thing that our survey showed, though, was that there was no place for individual dignity in the system.

Several of the hospital commanders or clinic commanders responded to our questions saying that military health care for dependents is a privilege, not a right, and that is their firm conviction.

If you believe in the trickle-down theory, it goes all the way from the top to the bottom and that is the way we are treated in military medical facilities.

Senator WILSON. The implication of the testimony, I think, is that, for whatever reason, the answer from the standpoint of achieving the quality of care that you desire for families, it is pointing more and more toward the use of civilian medical care, HMO's, through things like the PRIMUS experiment.

Dr. O'BRIEN. Right. I think there are a lot of options out there right now to be explored. I think there are a lot of cost-effective and yet quality care alternatives that can be used for the military family. I think that they probably are more cost effective than what we have now.

Senator WILSON. Has there been sufficient experience yet for you to be able to answer as to whether or not there is a continuity of attention in civilian care that is absent in the military?

Dr. O'BRIEN. It is like day and night. If someone is unable to get care on an outpatient basis at a local military hospital and they go to a civilian health care provider and during the course of their treatment it is discovered they need inpatient care, in all likelihood they will be denied that right and they will be told to return to the military health care system for whatever inpatient care is needed.

So, whatever the test results, whatever care has been provided previously by the civilian physician, it is all ended and the person must start all over again in the military system.

There is no continuity in the medical treatment and there is no continuity in the patient-physician relationship, which is so important to wellness.

Senator WILSON. In your formal statement, your association says that you fully support increased wartime medical readiness and agree that more physicians must receive more surgical training, but at the same time building the skills for that wartime readiness should not influence whether surgery is to be performed by military physicians or by CHAMPUS providers.

I take your point, but how do you suggest that the surgical skills be obtained by the military physicians?

Dr. O'BRIEN. I think it has been suggested in the hearings that I have been to, previous hearings that you have held, that there are some alternatives where physicians in the military receive practice by going to clinics in the civilian sector for that kind of practice.

But just to have people to practice on, I think is questionable and it is frightening to us because we have no control over whether we get a CHAMPUS availability and use our civilian health care providers or whether we use military health care providers.

Senator WILSON. Thank you very much.

Dr. Skillicorn, I am not sure whether to be optimistic or pessimistic as a result of listening to you. I am, first of all, very grateful to you for coming all the way from San Jose and sharing with us your expertise this morning.

You have indicated that you think that by virtue of the organization, and I would say also the responsiveness to demostrate the will for reform from the top, that military medicine may have the opportunity to afford a model for civilian medical practice.

I share that optimism. I think some of the efforts that we have seen in recent times warrant the optimism.

What I am really concerned about, and I guess I should have made it clear this morning, is developing the exact procedure that will give us assurance of the kind of accountability that you find notably absent in civilian medicine and that clearly has been absent in all too many instances in the military, the celebrated instances of Dr. Billing and the others, and, of course, the story that Mrs. Day has told us this morning is one that evokes not only our sympathy for her tragic loss, but outrage that it was permitted to occur.

The thing that I think makes your testimony most valuable is that it seems that you have had experience with the difficulty of bringing about that kind of accountability in civilian practice.

We have heard in previous hearings about the extensive regulatory scheme set up within the Department of Defense to help ensure quality care, changes in credentialing, the peer review, and at the same time we have several reports that clearly show that making such a scheme work at the hospital level is the most difficult part of the process.

I gather that this not only matches your experience in the contact with the civilian medical practice.

What specific thoughts do you have about how the concept of quality assurance can be both made more acceptable to individual health care providers, civilian and military, and what specific procedures would you prescribe with regard to bringing about account-

ability in the military and maybe equally applicable in civilian life, but in civilian life malpractice is a fact of life.

Today at least the *Feres* doctrine applies in regard to military medicine and there are some who I think have made clear their dedication to the highest quality medical care who think that the *Feres* doctrine should continue to apply

Obviously, Dr. Mayer is one. He said he has not taken a position on *Feres*, but it is clear he is devoted to quality medical care.

What would you prescribe to assure accountability in the absence of repeal of the *Feres* doctrine?

Dr. SKILLICORN. We need a seminar, Mr. Chairman, to answer that. Very briefly, I have long believed the best way for the industry, for the health professionals, to address the problem of malpratice, malpractice crisis, is to begin to correct malpractice.

That is another way of saying instituting stonger quality controls because I think they are related. How do you do that?

My experience has been that you have to have commitment at the highest level, obviously with support, to bring it off.

That is very difficult because we live in a world of turfs, unlike any I have ever seen, in the health care industry. That is: "That is my nitch, leave me alone."

In the health care field it is hard to break through. Working at the local level of care I find that to make quality assurance controls acceptable, you have to involve the people who are dispensing the care. You have to involve the peers, you have to get them to become convinced this is good for patient care.

It is not just a matter for them, the professionals, to have someone looking over their shoulder; they have to see there is a yield in the improvement in patient care. You have to appeal to their professionalism.

The state of professionalism, of caring, is very high in the health care industry. We are very fortunate for that. Most of the attempts have been made to impose things on the profession. We make massive rules and regulations.

I have noticed in the military service, there is a dispensing of massive directives telling everybody what to do. The response to that often is very, very reactive in a negative way. You have to have policies and directives, but if it is going to work, the people at the lower level have to be convinced it is worth doing.

The other formula is that it has to be concurrent. Professionals are now oriented. They are with their patient now, today, doing what they want to be doing. That is why they went into the profession. A reprimand about a complication rate 6 months later really does not have much meaning to them. They may not even remember the patient. It has to be concurrent. It is not very easy to do.

It is very hard to monitor care while it is happening, but we have to learn how and we are beginning to.

Those are the things I think have to be done. Involve the peers themselves, demonstrate to them the techniques to enable them to do that, not misuse them. We have a knack for misusing professionals, putting them on committees, paper shuffling, having them do what they were not trained to do and are not interested in doing just because we think it is a good idea.

We have techniques that can screen most of that for them and leave the professionalism up to them. It is going to take a lot of resources and a lot of commitment to do this. I see the dedication to do that already, with the little exposure I have had recently to the military. I have seen more dedication there in a very short period of time than I had seen in 10 years in the civilian sector.

I think they are ready to provide support and resources. I think they are getting a good start, credentialing and licensing. That is only a start. The task is extremely formidable, but it is going to have to be done.

I am beginning to be optimistic that maybe the military will lead the way. I do not like the remarks that infer we have to look at civilians in this case as the model. God help us, because our civilian activities have a lot of problems.

Granted, they do provide those aspects of quality care that I am hearing here today that they do better than in the military in a number of ways. The continuity of care, timeliness of care, dignity of care; those are quality issues to patients.

I have seen very few patients who question the scientific excellence of care. They take that for granted. They question the adequacy of the delivery of care.

In the private sector, particularly now with the competitive nature of it, they take great pains to provide those necessities so that they can get a piece of the marketplace. That has to be corrected in the military too.

Senator WILSON. I think you are making good sense.

When you say concurrent as opposed to after the fact analysis so that we can achieve prevention rather than reprimand, how would you go about that?

I am having some difficulty. I envision someone at television central monitoring about four different operating rooms.

Dr. SKILLICORN. That would be nice. I mean it is very difficult. Let me give you an example of one of many that I have instituted.

We spent as a committee 8 years looking at the misuse of antibiotics. We are talking about big, big business. We have discovered nationwide about 40 percent of antibiotics use is inappropriate.

We set out to do something about the Joint Commission on Accreditation of hospitals mandating that we have to have special reviews on antibiotics. For 8 years, monthly meetings, looking at the use of antibiotics, discovering they are being misused, holding educational programs, having them monitored; in 8 years it did not change the pattern at all.

It still remained 40 percent inappropriate use of antibiotics. A year ago the committee finally revolted. There was no yield. They were tired of retrospective reviews, and asked me to develop a new system. We developed a concurrent system.

We now have a clinical pharmacist who makes daily rounds while patients are in the hospital when the doctor orders the antibiotic. He evaluates it for appropriateness of dose, timing, and so forth, and they have a little form reminding the doctor that probably better use could be done.

Within 6 months we had more change in the practice style of physicians than we were able to accomplish in 8 years. It was timely, made sense to the doctor. He was getting assistance from

somebody who knew more about antibiotics than he did. It has been accepted.

We are beginning to install monitoring of things while they are being done. I am beginning to ask our physicians, especially our own peers, to established certain clinical conditions and to develop criteria when a patient with that condition comes in, get a consensus of what are the things that should be done and the things that should not be done for that case.

Then we can monitor their performances, nurses can monitor. Others can monitor. When there is an exception to what was agreed upon as the usual way to handle that case, we call in a peer physician for reviewing.

I am not saying do away with retrospective reviews. But to rely solely on our present system is cruel to patients. It is using patients for learning whether we are doing good or bad.

Senator WILSON. What was the reaction of the physicians who were handed this diplomatic form by the attending pharmacist?

Dr. SKILLICORN. Almost uniformly positive with one or two exceptions. There are always one or two physicians who will take exception. They don't want anyone to look at them.

It was accepted because it made sense. Twenty-five percent of those who were monitored discontinued treatment when it was brought to their attention, discontinued the antibiotic because it was unnecessary. They had been in the habit of routinely ordering them.

Senator WILSON. Can you tell me how much peer review, as it is presently being performed in the civilian medical sector, is purely retrospective?

The name "review" implies it is entirely retrospective.

Dr. SKILLICORN. I would say close to a hundred percent, easily 98 percent of reviews are retrospective reviews. Our whole system is built on the concept that adversity has to happen and then we will review it.

We review death charts, we review complications, we review hospital-acquired infections. We have a smugness, we have a comparison mode in our mentality. We immediately question, when we find complications or nosocomial infections, what is our rate?

And you are given the rate, whatever it is, 2½ percent of all cases, that is our rate. The next question is: What is the rate of somebody else or what is the national rate?

Somebody will look it up very quickly and say 2½ percent. Oh, that is great, we feel good because we are no worse than the national rate. The fact that the national rate is a national scandal does not seem to bother anybody.

That is my point. We have a system that is almost designed to meet minimum requirements, and that is mediocre. That is why I do not like comparing.

The system is built on after the fact and being sure you are not worse than somebody else. I do not accept that as good quality care.

Senator WILSON. Is the experience sufficient in this field so that you can give some reasonable estimate of whether or not the kind of current procedures you are talking about have heavy cost implications?

Dr. SKILLICORN. No, let me put it in easily understood terms.

Whatever it costs to install these systems, if they save one malpractice suit in five years, they have paid for it all, easily. I know they will save more than one malpractice, one tragedy. So, I am always asked what is it going to cost?

Quality is not cheap, but the lack of quality is not cheap either. That is what our findings are beginning to reveal.

Senator WILSON. If 98 percent of the physicians in this pioneering effort with the pharmacist responded positively, and if, as you have just testified, it offered the potential for cost savings by eliminating a substantial amount of malpractice, why is it that so little peer review is concurrent?

Why is it almost entirely retrospective?

Dr. SKILLICORN. Resistance. This happened to be a winner because it helped the doctor with his clinical practice. Concurrent review has not been tried. It is a relatively new concept.

As I said, the things that are currently being recommended to expand our retrospective review, I think are going in the wrong direction. We tend to look at patterns and trends of what we have done. Our reaction should be what is happening to the patient today.

Senator WILSON. So, there is a selling job to be done to the medical profession?

Dr. SKILLICORN. Yes, the industry. As I said, because of the fragmented nature of the organization and authority, the ability to get things done and to get them to make up their minds to do them does not exist in the civilian system.

Every hospital is an island unto itself. I have not been in two hospitals that have the same system. They have different politics, they have different resistances, games that are played, turfs that you have to deal with; it all is very complicated.

I have been at it for 10 years and I am not getting younger. I am not sure I will get much done either. However, there are signs that we are ready. Malpractice has something to do with it. Because of the growing magnitude of it, people are saying we have to do something about the way we are practicing medicine.

In that sense I think malpractice is very good. I think there has been more attention directed toward the need for better quality control instigated by the malpractice crisis over the years than the industry itself has instigated.

Senator WILSON. It strikes me that you might have an effective partner in attempting to persuade the profession and that is the insurance companies who insure malpractice. Of course, their response is to leap out of the field.

I would be more than curious to find out what response, if any, these pioneering efforts have evoked from malpractice liability insurance.

Dr. SKILLICORN. Part of the need is reporting, and I have recommended this to the Department of Defense. It was one of the weaknesses I did note in the military when I had the opportunity to evaluate a military hospital recently by invitation.

They had good quality control, as good as I have seen in any civilian hospital, but they had a major weakness, and I see it as a constant. Somehow that has to be corrected.

The military, again by its nature, has a very vertical system for its reporting system. You brought this out earlier with the previous testifiers here. If the private has a concern and he needs to express that, where does he go?

We have the same problem in civilian hospitals. If something goes wrong in a patient care unit and the staff nurse sees the doctor do something bad, what does she do with that?

It is a vertical reporting system. She has to go to the head nurse, supervisor, chief of nurses, maybe the administrator. If it does get through that vertical reporting system, what do you suppose the administrator is going to do?

Do you think he will tell the medical staff to look at that doctor? No, politics does not allow that. Or worse, if the nurse sees something wrong in the unit and the supervisor is deficient, who does she report it to? To the supervisor?

She will not report it because of retaliation. We got around that. Although it is necessary for authority to have a vertical reporting system, it is very inhibiting for those who have concerns about patient care because it is a tough system to get through.

We developed what I call a horizontal reporting system, a second opinion, if you would, type of reporting system through our quality assurance program in the hospital. Our quality assurance program has a multidisciplinary special committee that looks into the problems as a whole to see that they are corrected.

The major part of our system is a confidential reporting system. I get seven or eight of them every morning I open my door, slipped under my door, coming from nurses, people in the laundry, couriers, or whatever, expressing a real concern that would never have been reported otherwise.

They would never be identified, many of them extremely serious. We take that and go to work on it, validate it and get it in the proper hands to handle it.

Not so in the vertical system. The vertical system has approved our doing this. We have put pressure on them to respond to that. That has been one of the most powerful tools of opening up the accessibility to get somebody else to look at a problem other than the people who are superiors.

The vertical system is a very suppressive sort of system to work under. I recommend setting up a separate quality concern reporting system in institutions. I realize it would have all kinds of ramifications for the military, but I would like to see it attempted.

Senator WILSON. Dr. Mayer, it sounds like something you would want to discuss with Dr. Skillicorn.

Dr. MAYER. We have and we will.

Senator WILSON. The hour is late. I want to thank the witnesses who have been generous with their time, including the time taken from their own schedules, to travel and come here.

We are most grateful to Mrs. Day, a representative of many parents. We thank you for your eloquent testimony. I can tell you that I think it is clear from what we have heard today, there is a determination to prevent the kind of tragedy that beheld you to the extent that it is humanly possible to do so and to increase the quality of care generally.

Let me, by way of announcement, indicate that it is the intention of the Chair to hold another hearing on the subject of military health care. We do not have a date for that hearing yet.

The purpose of that hearing will be to address some of the as yet unaddressed concerns having to do with the kind of problems that Dr. O'Brien was discussing relating to the level of service and to some of the alternatives as they relate particularly to the peacetime care and care of civilians because there is a disconcerting, almost constant theme appearing through all three of the hearings and that is the conflict in missions between the wartime priority mission and the care of the dependents.

We have not resolved that and must do so.

Thank you very much.

[Miscellaneous correspondence received by the subcommittee follows:]

PREPARED TESTIMIONY OF CONGRESSMAN DANTE B. FASCELL

Mr. Chairman, I appreciate having the opportunity to express my views to the members of the Subcommittee on Manpower and Personnel regarding a very important matter.

I have in my district a fifteen year old boy, Billy Bostik, who was born with Eisenmenger's Complex, a condition causing severe hypertension, and a buildup of blood pressure and blockage in both lungs. He will soon be in need of a complete heart-lung transplant if he is to survive. The cost of this surgery is around $250,000—more than his family has been able to raise after years of trying. Billy's other medical expenses are covered by CHAMPUS, since his father serves on active duty. However, because heart-lung transplants are still considered experimental, CHAMPUS will not pay for life-saving operation Billy needs.

A few weeks ago, Billy's dreams came true when a Saudi Arabian Prince, hearing of his plight, donated the needed $250,000 for the surgery. Billy was lucky. What about the others who suffer?

Under current law, CHAMPUS is authorized to pay for liver transplants when the military dependent is considered appropriate for the procedure by the Secretary of Defense, in consultation with the other administering Secretaries, and the transplant is carried out at a health-care facility that has been approved for that purpose.

This is all that is written in the statutes and it has, in the past, led to very ambiguous interpretations when applied to organ transplants other than livers. For example, CHAMPUS will reimburse for kidney transplants, considered by the medical and insurance industry to be a "standard medical procedure". However, CHAMPUS has refused to consider reimbursement for heart transplants on the basis that it is still experimental and is not statutorily authorized.

During the consideration of the Department of Defense Authorization bill in the full House of Representatives, I offered an amendment which would authorize CHAMPUS to pay for organ transplants for authorized military dependents, in approved health centers, when the procedure has been deemed non-experimental by the Secretary of Defense in consultation with other administering Secretaries. In doing so, the amendment shifts the responsibility of authorizing transplant procedures from the Congress, as mandated by specific statutes, to the appropriate agencies with oversight of such state-of-the-art techniques and advances. The amendment was not intended in any way to give authorizing authority to CHAMPUS for coverage of all organ transplants. It simply would allow the administrators more flexibility in using good judgement to advance the policies of the CHAMPUS program, as the state-of-the-art in transplant surgery also advances.

It is extremely important that CHAMPUS, the insurer of military dependents, keep pace with federal and private sector insurance policies. It would be a tremendous tragedy if young people such as Billy Bostik were denied the opportunity to receive these organs simply because he was born a military dependent. While it was not the intention of this amendment to put CHAMPUS out in front as a forerunner of the insurance industry, it was intended to ensure that CHAMPUS does not lag behind.

The cost of such legislation cannot be computed in any exact amount. However, it should be noted again that this change does not mandate the coverage of any organ

transplant procedures not how covered by CHAMPUS. It assumes that when new organ transplant procedures can be considered standard medical practices, the added "on-the-table" costs of reimbursement may compare favorably with the mounting "off-the-table" cost which CHAMPUS now covers in caring for military dependents at least in some cases.

While this amendment was agred to by the full House of Representatives, it was not included in the Conference report. However, as the Members of this Subcommittee give further consideration to military benefits and consider possible legislation, I hope you will include a provision insuring that care of CHAMPUS recipients does not lag behind those in the majority of insurance programs—government and private.

DEPARTMENT OF THE NAVY,
OFFICE OF THE CHIEF OF NAVAL OPERATIONS,
Washington, DC, 3 December 1985.

Hon. PETE WILSON,
Chairman, Subcommittee on Manpower and Personnel, Committee on Armed Services, Washington, DC.

DEAR MR. CHAIRMAN: Thank you for the opportunity to comment on the report "The Navy Dental Corps and Reorganization (1982–1983)," submitted by Senator Nunn, prior to inclusion in the military medical hearing of 8 October 1985. TAB A contains my comments on the report, prepared on form DD 2136, as required for inclusion in the hearing record.

I appreciate your concern for the continued delivery of top quality dental care to our military beneficiaries. It is my firm belief that the restructured Navy Medical Department is a sound and functional framework for management of the overall Navy health care system.

Sincerely,

LEWIS H. SEATON,
Vice Admiral, Medical Corps, United States Navy, Director, Naval Medicine.

[Enclosure.]

Admiral SEATON. I appreciate Captain Lanier's interest in the Navy Medical Department's progress to improve the total health care delivery to our military beneficiaries.

The realignments and functional changes made by the restructuring of the Navy Medical Department made major changes in Navy health care management, including changes in the Dental Corps. This restructuring reduced the span of control at all echelons of command to improve command, control, quality of care, and readiness throughout the Navy health care delivery system. I believe the changes made have strengthened command and control functions and help to ensure help to ensure our readiness to meet wartime commitments.

Preservation of expert oversight of the delivery of dental care is assured by the Assistant Chief of Staff for Dentistry (ACOS) at every regional Naval Medical Command. This ACOS is also responsible for budgetary matters for the dental facilities in the region and protecting them from the competing interests that Captain Lanier referred to. Two of the eight geographic commanders themselves are now dental officers. All Navy Dental Commands and Dental Clinics are commanded by Dental Corps officers. This leaves the ultimate control over substantive issues of dental care with Dental Corps officers.

As a result of the restructure, Dental Corps officers in the Navy Medical Department have greater opportunities for command and senior management positions. Assignments to these positions have been made on the basis of the "best qualified" Medical Department officer, regardless of corps. The renowned excellence in management of Navy dental officers has brought to bear at all echelons of command of the Navy Medical Department. This has ensured that Dental Corps leadership is integrated and effective, rather than separate but equal.

Although there has been a change in autonomy with the restructing, the new fully integrated Navy health care delivery system has not shown loss of dental productivity. In fact, since 1982 our productivity, as measured in composite time values (CTV) per dental officer, has increased from 9,872 CTF to 10,805 CTV in 1984. The figures for 1985 are not yet available but can be provided at a later date. This can hardly be the result of "chaotic management" and "benign neglect" that Captain Lanier refers to. Since morale and productivity are intimately linked, morale at the "grass roots" level does not seem to have been adversely effected. This I attribute to the excellent leadership of Rear Admiral Shaffer as Chief of the Dental Corps.

Other issues such as dental officers special pays however do impact on morale. The climate of uncertainty in dental continuation pay prevalent over the last two years would concern any dental officer considering a Navy career. We have been successful with the help of Congress in getting a dental special pays program, patterned after the successful physician special pays, authorized this year. We await the appropriation of monies by Congress to support full implementation of this program.

I agree with Captain Lanier that changes in any organization are successful only to the extent that they can be objectively used, modified, and refined to perfection. The evaluation of the restructure is ongoing. As a result of the Dental Policy Review by the Office of the Assistant Secretary of Navy (Manpower and Reserve Affairs) the following adjustments in the organization have been directed: (1) Establishment of a Dental Division within the Office of the Director, Naval Medicine headed by the Chief of the Dental Corps and (2) Establishment of a single code within the Navy Medical Command, headed by a Dental Corps flag officer, to address all dental operational issues.

PREPARED STATEMENT OF SGT. MAJ. C.A. (MACK) MCKINNEY, USMC RET., LEGISLATIVE COUNSEL, THE NON COMMISSIONED OFFICERS ASSOCIATION OF THE UNITED STATES OF AMERICA

Mr. Chairman. The Non Commissioned Officers Association of the USA (NCOA) appreciates this opportunity to comment on Military Health Care. NCOA is a unique association. It has the largest number of active duty military enlisted personnel in this worldwide membership of any quasi-military organization. Together with those who are retired military enlisted servicemen and servicewomen, NCOA can offer much insight into the care available to and received by nearly 500,000 people in the military community.

It is important to first note there is much difficulty in attempting to cover the vast expanse of military health care in this one statement. The subject matter is so varied and complex that it would take volumes of text to address each of them. Nevertheless, NCOA believes current announcements from the Defense Department and the hearings being conducted by Congress are coming so fast that it needs to fire a warning shot- the issue of military medicine cannot be resolved in a matter of a few weeks or months.

It also is of importance to establish responsibility. Despite interpretations of law that state the federal government has only a moral obligation, NCOA strongly endorses a legal responsibility on the part of the U.S. government to provide "free" medical care to the majority of the military community. For years governmental agents (recruiters, reenlistment counsellors, commanders, etc.) promised free medical care for those who enlisted, remained on active duty and eventually retired. The same promise held fast for their dependents and, in some cases, their survivors. Not only was this promise given verbally but appeared in print in recruiting and other military publications.

Kudos are extended to the military for doing its best to keep that long-time promise alive but military health care is plagued with problems. It has a larger military community to serve than anyone ever anticipated. It has a shortage of doctors and, in some cases, *trained* medical professionals. It has a world-wide mission that spreads its resources to the limit. It has a shortage of funds and equipment. It has Congressional oversight panels which sometime detour that determination to do its best to carry out the promise. If the military is being called on the carpet for malpractices, diagnostic blunders, interservice rivalries, long waiting lines, impersonal services, etc., it's of no great wonder.

This is not to say the system cannot be improved. Congress could create a wartime reserve capability. It could encourage all doctors and medical professionals to undergo military training. Not a favorable political move but nevertheless a smart one. If the United States goes to war, it will have a medical corps at the ready. Congress also can brave the deficit problem by appropriating additional funds for overseas hospital construction and prepositioned facilities.

At the same time Congress should do what it can to improve peacetime medical care. Again it could appropriate more funds—funds, for example, to pay greater bonuses to medical professionals who serve a tour on active duty. If Congress can overlook the social security program in its effort to reduce the deficit, which it should do, it certainly can excuse the military health system. Most Social Security recipients have earned their entitlements through monetary contributions over the years to the social security program. Military personnel have earned their entitlement

through their personal contributions to the nation and its citizens. No legislator should ignore the fact that the social security system survives only because the nation's soldiers, sailors, marines, airmen and coast guardsmen have assured the country's existence for more than 200 years.

To NCOA it's a shame our nation's legislators will not stand tall and justify the existence and continuance of our military health program. Surely there's no need to apologize for doing everything possible to keep a solemn promise made to those who serve their country in uniform.

Regretfully, military health care is not a glamorous subject. It generates news only when the system produces a failure. When it become a subject of congressional hearings the major issue is one of costs rather than support. It becomes entangled in the bureaucratic maze one calls the Defense Department; whereas, the Pentagon requires each military service to determine its needs and requirements then lumps what it wants in one big request to Congress. Last, but not least, the DoD request is divided in to two proposals that must be dissected by at least six congressional committees.

This association has advocated many improvements over the years without much success. One was to authorize full CHAMPUS coverage for dependents who accompanied their active duty sponsor to assignments outside military catchment areas. The House agreed to the suggestion incorporating it in the FY 1986 Defense Authorization Bill only to have it removed in conference because of a Senate objection. What is there to object to in such an equitable proposal? If Congress subscribes to the military services assigning servicemembers to areas where their dependents cannot receive medical care, then it also should endorse full CHAMPUS coverage for those dependents. It's not the same as the military retiree who chooses to live outside a catchment area. In this case, the active duty member goes where he or she is ordered.

Also justifiable is the authorization to establish a limit on payments extracted from military personnel and dependents who have catastrophic illnesses. It is only right and reasonable to adopt limitations on their costs. But, again, the provision contained in the House version of the FY 1986 Defense Authorization Bill was negated by the Senate. The reason- to study the system.

The system already has been studied beyond a reasonable time. What is needed is action. What is most important is to gather the views of those who participate, not those who administer the program. In this respect, NCOA urges the subcommittee to listen to those who must use the military health care system, including CHAMPUS. What may be discovered could be an eye-opener to those who have oversight in developing and authorizing the system's programs.

As for the proposal to authorize active duty military personnel to file claims against the federal government for malpractice, NCOA has some reservations but not enough to outweigh the advantages such legislation could produce. Nevertheless, Congress must be extremely careful to provide language in the bill to offset any disciplinary problems that might occur and to insure that those who file such claims are not treated in a discriminatory manner.

In conclusion, NCOA has submitted these remarks simply to ward off any hasty decisions by Congress or the Defense Department in changing the current military health care system. All of us in the military community and those who oversee the program must have much more information available to offer constructive input.

Hopefully, such is forthcoming. Whether it does or does not, NCOA will be most happy to provide further testimony or written comments concerning this most vital and necessary benefit promised to our servicemembers.

Thank you.

THE RETIRED OFFICERS ASSOCIATION,
Alexandria, VA, October 11, 1985.

Hon. PETE WILSON,
Chairman, Armed Services Committee, Subcommittee on Manpower and Personnel, Washington, DC.

DEAR MR. CHAIRMAN: The Retired Officers Association (TROA) has its National Headquarters at 201 North Washington Street, Alexandria, Virginia. The Association has a membership of over 342,000 retired, former and active duty officers of the seven uniformed services. Included in our membership are almost 44,000 widows of former members. Although we would have preferred to provide verbal testimony during the recent hearings, we appreciate this opportunity to submit for the record our views on the vital issues of military health care.

Unfortunately, highly publicized horror stories about military medicine have given critics an opportunity to dust off two ideas which have been considered and discarded in the past: creation of a super agency to control and coordinate all military medical activities; and meeting and health care needs of all but active duty personnel in other medical facilities in the public or private sectors.

For the retiree and his dependents, health care is second in importance only to retired pay. The recent press coverage plus the hearings before the Senate and the House Armed Services Committees have sharply increased concern among our members as to the accessibility, quality, and cost of their health care in the future.

With respect to a super agency, common standards and coordination can be achieved among the three services without the need for creating another costly and obstructive level of supervision. Considering the growing shortage of personnel resources, the diversion of even more people from operations to management seems illogical.

Furthermore, limiting the spectrum of care to the active force would be disastrous. For one thing, no young medical professional worth his salt would be attracted to a career limited to the needs of a young, healthy, population. But, more important, the resultants small and poorly prepared corps of military providers would be overwhelmed immediately at the outset of combat at any level.

This critical consideration arose during one session of the Blue Ribbon Panel on Military Hospital Sizing when a panel member questioned now dependent and retiree care in military facilities contributed to the ultimate objective of combat readiness. Lt. General Bernard Mittemeyer (then Army Surgeon General) responded to the effect that such care was not only essential in attracting the most qualified professionals, but also was needed to give those professionals training and experience in combat related skills—skills that would otherwise remain untested in peacetime.

The handling of casualties after the Beirut Marine Barracks bombing is identified as a case in point for increased coordination among the services. A totally unfounded charge is that an Air Force general, with a parochial bias, bypassed Army Hospitals in Landstuhl and Frankfort, Germany, to assign all casualties from two medical evacuation aircraft to the Air Force's hospital at Weisbaden. The fact is that the general was not serving in an Air Force capacity, but as the chief medical officer in the (joint) European Command. He was given an early estimate of 100+ casualties when there were actually 37. the two air evacuation aircraft involved carried 24 and 13 casualties, respectively. From the first aircraft he assigned 13 to Weisbaden, nine to Landstuhl, and one to Frankfort. (One casualty died en route to Germany.) From the second aircraft, he assigned three to Weisbaden, nine to Landstuhl and one to Frankfort. The current Army Suregon General, Lt. General Quinn Becker, has attested to the fact that the dispersal was proper, had no parochial connotation, and was made in the best interests of the casualties.

Arguments for and against competition among the services notwithstanding, military medical service is one of the best examples of service cooperation. One of the few bright spots in our Southeast Asia experience was the Army/Navy/Air Force coordination which resulted in saving hundreds of lives which would have been lost in previous wars. Today, the three suregons general work in almost total harmony, sharing patient population from the active force, their dependents, retirees and their dependents.

The military medical services, like all the combat arms, must constantly prepare for combat in peacetime. They do this by performing procedures similar to those needed in war. One common misconception is that OB/GYN capability is non-essential when in fact the current active force is 12 percent female and projected to rise to 20 percent. There is also a continuing requirement to care for female dependents overseas and the best preparation for treating combat wounds is OB/GYN surgery involving the stomach and pelvic regions. Other so-called experts assert that pediatric practice is non-essential to preparation for combat medicine. Yet, among all medical specialists, pediatricians are the most experienced in maintaining proper electrolyte balance in young patients—experience that is equally vital in saving combat wounded in shock.

Dr. Mayter is right when he states that the current active medical services will not suffice in the event of a ground war in Europe. But he's dead wrong in the solutions he recommends. The immediate solution is increased authorization of medical professional and support personnel.

From our perspective, the greatest challenge for military medicine at this time is to revitalize and reassure those in the military medical service who are now severely demoralized by the effects of publicity given to the incompetence of a small fraction of their number. Under the current conditions, we may lose the best of our

military health professionals whether or not their medical practice is restricted to active duty personnel only.

Although most authorities agree that medical malpractice in the military (only one malpractice claim per 64,000 clinical visits last year) is no greater than that experienced in other health care systems, recent incidents were highlighted during hearings in both the Senate and the House. These incidents have also created considerable pressure to statutorily override the Feres doctrine.

We have heard and examined most of the arguments for and against the Feres doctrine and remain committed to it in principle. For the military to remain a strong and effective fighting force, service leaders must retain their unequivocal rights to command with no question as to the duty of their subordinates to obey them. However, if the Feres doctrine were overruled by statute, this superior-subordinate relationship and the unhesitatingly decisive action and equally disciplined response associated with it could be undermined to the detriment of mission accomplishment. Morale would suffer if, in the process of litigation, servicemembers were required to testify for or against their friends or superiors. Scheduled military operations, deployments and overseas assignments could be hampered significantly by the need to make principal witnesses available for pre-trial and trial proceedings. Finally, it would require the courts to "second guess" military orders and therefore intrude into, if not interfere with, legitimate military matters.

If an equally viable alternative were not already available, there might be a sense of urgency about enacting remedial malpractice legislation. However, the military already has a less obstructive alternative to deal with the issue of death or disability arising from medical malpractice: the military compensation system. Although improvements in some elements of compensation are necessary, a comprehensive package has been skillfully crafted to deal with the exigencies of military service and includes a disability retirement system for servicemembers permanently injured in the line of duty, free medical care in military facilities, unlimited sick leave with full pay and allowances until return to duty or release from active duty and limited survivor benefits. The distinct advantage of the military compensation system over the malpractice alternative is that the former insures fair, equitable and consistent application regardless of where the service member is stationed. Consistency is a feature that would be sorely lacking in the litigation alternative. Under that approach, compensation for service connected injuries or death due to negligence would be totally dependent on local law. This would be patently unfair to the servicemember who has no choice in duty assignment.

In summary, the Feres doctrine has survived the test of time, without alteration and for good reason. It enables the Armed Forces to accomplish their mission, unencumbered by judicial intrusion. Inadequacies in the current compensation package for injured and disabled servicemembers, and those who die in line of duty should be remedied rather than resorting to an alternative which has such great potential for interfering with the military mission. In addition to improvements in disability benefits, significant increases in death benefits would be necessary to round out the package. A key ingredient in such an alternative would be a triple or quadruple indemnity life insurance plan funded by the government.

Member and family morale is undeniably an essential factor in military readiness. Yet, a major shortcoming in existing medical entitlements has great potential for undermining that morale: the non-existence of catastrophic loss protection under CHAMPUS.

Most major medical plans in the private sector and the Federal employees' health benefits program provide a limitation on out-of-pocket expenses for co-payments and deductibles once a certain threshold has been reached. This limitation or catastrophic cap varies from plan to plan. For the Blue Cross/Blue Shield Federal employees' program, for example, the annual catastrophic cap is $1,500 for the high option plan and $2,500 for the standard option plan.

CHAMPUS contains no such limitation. Without such a catastrophic cap, a long illness has the potential of wiping out a family financially with a correspondingly adverse impact on their morale.

In its version of the fiscal year 1986 Authorization Bill, the House Armed Services Committee recommended an annual out-of-pocket limit (catastrophic cap) of $1,000 per family for active duty personnel and $3,000 per family for retirees and survivors. As we understand it, this provision was deleted in conference by the Senate so that comprehensive hearings could be conducted. With these hearings now ongoing, TROA would like to underscore that we strongly support CHAMPUS catastrophic caps at the levels proposed by the House and recommend immediate action to enact them.

Dental care is another area which requires prompt attention. The fiscal year 1985 Department of Defense Authorization Act authorized active duty dependents to receive space-available dental care at military installations throughout the United States effective July 1, 1985. Although not the intent, that law has effectively eliminated space available dental care as an option for military retirees. This results because the statutory language assigns active duty dependents a higher "Space-A" priority than retirees and their dependents and because the services dental staff predictions that the differing dental care needs of the two populations would obviate any loss in benefits did not materialize.

The impact of this loss of a longstanding benefit is now being felt by the retired population. In some cases, retirees seeking military dental care heard such startling revelations as, "there will be a one year wait" or, "you are 8,000 on the waiting list." Needless to say, morale has suffered. To partially redress this unexpected turn of events, TROA strongly recommends that the law be changed to accord retirees equal priority with active duty dependents and that "Space A" dental care be offered to all beneficiaries on a first-come, first-served basis.

In a related matter, even with their top priority, "Space A" dental care has become a hollow promise for active duty dependents. Sufficient space is not available to accommodate the demand. Therefore, we strongly recommend that this committee actively promote the premium-sharing dental benefit plan for active duty dependents contained in Section 651 of S1160, the FY 1986 Department of Defense Authorization Act. Although dental care was not a common feature of private sector health plans when the services transitioned to the all volunteer force in 1973, it has become increasingly so in recent years. In order to remain cmpetitive with private industry employers, who direct recruiting efforts at skilled, mid-career military personnel, the services need a dependent dental care benefit as part of their total compensation package. The proposal now being finalized by OSD will accomplish that objective and should be implemented as expeditiously as possible.

Finally, as far as The Retired Officers Association is concerned, "the jury is still out" with respect to the Civilian Health and Medical Program of the Uniformed Service. Innovative concepts such as the use of Health Maintenance Organizations (HMOs) and the Army's PRIMUS (Primary Care for the Uniformed Services) Program need to be tested and examined. If successful, they should be promoted as alternatives to CHAMPUS. The underpinning of any such program must be to enhance individual dignity, which is severely diminished in the military installation clinical setting, and to greatly improve continuity of care. This critical health care concept is virtually non-existent under the current formula which leans on CHAMPUS for out-patient care but mandates military facilities if follow-on inpatient care is necessary. The latter is a recent phenomenon which emanated from OSD cost containment measures. Prior to 1984, OSD policy recognized the medical significance of "continuity of care" and permitted a beneficiary to receive follow-on inpatient care in civilian facilities without regard to the availability of military facilities.

In concluding our submission, we respectfully request that our statement be included in the formal hearings record on wartime and peacetime readiness. We would welcome the opportunity to expand on our remarks or answer any questions the committee may have.

Sincerely,

LEROY J. MANOR.

AMI,
Beverly Hills, CA, September 30, 1985.

Hon. PETE WILSON,
Chairman, Subcommittee on Manpower and Personnel, Committee on Armed Services, Washington, DC.

DEAR MR. CHAIRMAN: Regrettably, I have been unable to resolve the conflict in my early October schedule that I mentioned during our discussion in Irvine last week. Consequently, I will not be able to appear before your subcommittee on October 8 in connection with your hearings on quality assurance in the military health care system. I am particularly disappointed at this turn of events because I consider quality assurance to be second in importance only to medical readiness among the vital issues facing the military medical services today.

Although I will not be able to be in Washington next week, I would like to summarize for you my views on this issue.

When I resigned as Assistant Secretary of Defense for Health Affairs four years ago, I left the Pentagon firmly convinced that the military operates a first rate

health care system. Notwithstanding a disturbing number of media accounts to the contrary during the past year, I remain convinced that overall the system—as opposed to certain isolated parts of it—remains first rate. Unfortunately, in any large health care system tragedies will occur. The Defense Department operates one of the largest systems in the world with over one million hospital admissions per year and over 50 million outpatient visits per year.

Admittedly, confidence in the system has been shaken; however, I believe that my successor as Assistant Secretary of Defense for Health Affairs, Dr. William E. Mayer, has responded by launching a program to restore confidence. I also believe that the key step in that direction is his decision to use civilian peer review organizations to monitor systematically the quailty of care in the military system. I am confident that the outcome of the review process will support the contention that military health care compares favorably with civilian health care. I am equally confident that the strong support that Dr. Mayer is receiving from Secretary Weinberger, and from the latter's special medical consultant—Dr. Theodore Cooper, he will succeed in allaying the concerns we all share in this matter.

In addition to the utilization of civilian peer review organizations, the programs to place strict controls on granting of credentials for health care personnel, firm licensure requirements, limits on off duty employment, supervision of non physician health personnel and a tightening of the integrity of the DOD medical records system are of significant importance. In total, all of these initiatives together form an effective and cohesive quality assurance program. All of the initiatives are fully planned and some are in the implementation phase. I would encourage you to exercise your overview responsibilities in seeing to it that the Department moves forward expeditiously to implement the entire program. It is my strong belief that when all initiatives have been implemented, quality assurance within the military will equal if not exceed that which exists in the civilian health care system. Secretary Weinberger's remarks to the DOD Health Conference held on September 16, 1985 are a concise and effective statement of what needs to be done. I am attaching a copy of his remarks to this letter.

If you feel it would be helpful during the subcommittee's deliberations, I would have no objection to having this letter entered in the record of the hearings.

Please be assured that I will be pleased to help you and the subcommittee in the future in any way I can.

Sincerely,

JOHN H. MOXLEY III, M.D.

[Attachment]

[News Release]

REMARKS PREPARED FOR DELIVERY BY HON. CASPAR W. WEINBERGER, SECRETARY OF DEFENSE TO THE DOD HEALTH CONFERENCE, HILTON HOTEL, SPRINGFIELD, VA, MONDAY, SEPTEMBER 16, 1985

Good afternoon, Ladies and Gentlemen. I welcome this opportunity to address you today because I have a very strong personal interest in the medical care provided to our fighting forces. It is not only a vital indicator of our readiness—but, and more important, it is part of the Government's solemn commitments we make to everyone in the military. It is a commitment we must and will keep.

I understand this is the first DOD conference that has been organized and so I am doubly grateful for the privilege of talking with you. As commanding officers of our medical facilities, you bear the burden of meeting these heavy responsibilities. Let me emphasize at the outset that I fully recognize the magnitude of your task. I deeply appreciate your efforts to accomplish that task.

This afternoon I want to discuss DOD's medical policies, both current and future, focusing on these critical and related areas: quality of medical care; readiness for war; and cost-efficient health care deliverly.

First, quality assurance. The Department of Defense has no more important responsibility than to provide the highest quality medical care to our fighting forces and other beneficiaries. Tragically, in the last several years problems have surfaced that fed the misperception by some that our is a second-rate system.

I remain convinced that the quality of our health care is good, and that it is administered by the finest health professionals of any armed force in the world. This point has been made repeatedly by Dr. Mayer—your strongest advocate—at the highest levels of decision making in the Pentagon and in Government.

But we do have problems to be solved. I strongly support the steps taken by Dr. Mayer to monitor and document the quality of medicine provided to our men and women in uniform. DOD policies requiring strict controls on the granting of creden-

tials for health care providers, firm licensing requirements, limits on off-duty employment, careful tracking of morbidity and mortality, prompt reporting of substandard care, and supervision of nonphysicians, are all fully on target with my concerns and priorities. More recently, I applauded and totally supported Dr. Mayer's decision to use civilian peer review organizations to monitor systematically the quality of care in our own system. Such professional review organizations have long monitored civilian medical practices.

So ours is a good system—perhaps the best. The burden is always upon us to keep our sytem one of excellence and to correct immediately any defects we find. And proving our worth is exactly what our quality assurance program is designed to do. There must be no question about that Department's commitment to ensure that there are no unattended problems in military health care.

We must erase any shadow of doubt about the quality of care we provide. Our medical corps must face the challenge offered by this system of excellence. The medical corps must commit to it—support it— and use it to demonstrate conclusively that we will accept no standard but excellence in our treatment of military people and their families.

Competition for acceptance into active duty in the medical corps has never been greater. We can now select from the Nation's top students those who actively seek the privilege of serving our armed forces as physicians.

In the future, this department will give even greater emphasis to quality assurance measures. We will be expanding our internal and external quality assurance programs to cover outpatient care, and to services in the private sector that we purchase through champus. We will be developing strict standards for the staffing and operation of emergency rooms, and better procedures to ensure the integrity of our medical records system. Compliance with DOD quality assurance policies will be closely monitored at all levels.

Turning now to medical readiness, all of you are familiar with the report by Dr. Ted Cooper and the blue ribbon panel on sizing of DOD medical treatment facilities. As you know, I concurred with this report and directed that its recommendations be implemented without delay.

This decision is intended to redirect the decisionmaking process to fulfill better our primary responsibility for medical readiness. This policy is clear: medical readiness will be the primary criterion for determining the size and composition of our medical corps, medical facilities, and training programs. The mechanism for accomplishing this is equally clear: Responsibility for allocation of resources to these purposes is vested centrally in the Assistant Secretary of Defense for Health Affairs.

To achieve our goals, we are beginning a top-to-bottom survey of all DOD health care facilities around the world. We will determine priorities for their replacement or repair as necessary to support the armed forces. This will end unneeded medical construction in the continental United States and conserve our limited resources for locations abroad where troops are deployed. Too often, these overseas medical resources have been allowed to decay while large medical centers in conus have flourished.

Another product of our concern for medical readiness will be changes both in the specialty mix of our personnel and in the training programs that produce them. Our current medical force structure does not meet the wartime needs of our primary mission—medical readiness. We are seriously short of surgeons, nurses, psychiatrists, and anesthesiologists who would be needed in wartime. Look at the composition of our active duty and reserve medical forces—and our training programs. We are weighted toward general medical care, including obstetrics and pediatrics.

I realize that these priorities came about in response to the demand for family-oriented medical care. But there are, in peacetime, alternatives for meeting these needs in the community where excess medical resources exists. In a war, however, the time to save a life is measured in minutes and hours. And in a combat zone, there is no substitute for properly trained active duty and reserve forces. Therefore, we must be ready.

Our first priority is to obtain the surgical specialties needed in a wartime theater. I expect Dr. Mayer to redirect and change the compensation of our medical force structure to ensure that it reflects medical readiness as the top priority for personnel authorizations and training programs. To accomplish this, he will convene a panel of experts to examine graduate medical education programs across all three services. The panel will evaluate what changes should be made in light of both our readiness goals and medical training opportunities available in the private sector.

I recognize that nearly three-fourths of our medical workload now is devoted to other-than-active-duty patients—dependents and retired people and their families—patients to whom we owe both a statutory and a moral obligation. But we can

achieve greater efficiency in the delivery of health services to all DOD beneficiaries without sacrificing our medical readiness goals.

For this reason, I am directing Dr. Mayer aggressively to seek arrangements with community medical resources where they are available and where they meet our high quality standards. Medical services can be made more accessible to our families.

I foresee several programs developing. They could include enrollment in health maintenance organizations, preferred provider groups, fixed price contracts under which civilian insurers would pay for our beneficiaries' health care, and the use of easily accessible outpatient care centers, such as that being established by the army here in Northern Virginia.

All are effective tools in improving the efficiency of our medical system.

However, I do not believe that we can afford such luxuries as fully staffing a military obstetrics unit for ten deliveries a month; or maintaining expensive training programs for medical specialties that are of little or no use in war. Similary, we will not spend public resources on the construction of expensive hospitals, clinics, and medical centers when quality services are available elsewhere in the community, and when there is no "readiness" reason for doing so.

What I have described is a civilian and military partnership for excellence in medicine—to help ensure quality and to conserve our resources to apply them first and foremost to the well-being of our troops. This partnership must be applied to our training programs as well. I see no need to perpetuate any system that produces an oversupply of physicians whose specialities are not relevant for our fighting forces in their time of greatest need.

A defense health agency has been proposed as a solution to the problems that occur in our system. We have attempted to address these problems by another means—through centralizing policy and resource allocation authority in the office of the Assistant Secretary of Defense for Health Affairs. I believe this approach can and will work.

However, establishing a defense health agency is a step that I will certainly take if the mechanisms we have put into place are not able to correct the problems in preparedness, quality, and cost that we face today. I am not concerned about the bureaucratic or political implications of any of the decisions facing us today, whether it be those affecting our teaching programs or hospital construction. As our first principle, I care only about using our medical resources effectively for our troops at times when they need it most. They deserve nothing less.

At this juncture, we have an opportunity to make important changes in our military health care system—changes that will result in lasting excellence in quality, readiness and efficiency. I see our system as a model to be emulated throughout the world. I invite you to join me in this. As I said at the outset, your efforts will determine the success or failure of the military health services system, and will shape its future.

We have in military medicine an outstanding team of dedicated and skilled professionals. I recognize and appreciate this, as do President Reagan, Dr. Mayer, and the vast majority of our beneficiaries. Working together, I have the utmost confidence that a system of military medical excellence can and will flourish.

PREPARED STATEMENT OF DR. O. DAVID WEST, HOSPITAL CORPORATION OF AMERICA

MILITARY HEALTH CARE

Mr. Chairman: On behalf of Hospital Corporation of America, I wish to thank you and the members of this subcommittee for affording me the opportunity to come before you today. We are not unmindful of the dilemma faced by this committee, the Department of Defense and our nation as well. Our dilemma is of how to provide quality, cost effective health care services, not only to our military members and their families, but to all the citizens of our nation. If we are to meet this requirement, we must find and employ the best ideas and obtain the full cooperation of both the public and private sectors. This dilemma becomes exceedingly complex and difficult when one recognizes that the Department of Defense has both a medical readiness mission, which is paramount, and a health benefit delivery mission to an estimated 10 million beneficiaries. Today, I would like to share with you some observations on the Military Health Services System (MHSS) and several ideas on how the civilian sector might assist the military in reaching the desired readiness posture and in providing a high quality, cost effective benefit to military beneficiaries.

Recently, I had the good fortune to be a member of the Blue Ribbon Panel which was established by this committee and charged to review certain aspects of the MHSS. This provided me a unique opportunity, and one that few of us in the civilian sector experience, to gain insights about the importance and complexity of the military readiness and benefit missions. It is with this understanding and appreciation of the problem that I come before you today, desirous of being part of the solution not part of the problem.

I fully recognize that the entire health care industry is undergoing radical change. This is resulting in many new and innovative ways of delivering health care. If some way can be found by working together in partnership to use the best of both the military and civilian systems, our patients will be the true benefactors of our efforts. This was stated very well recently by Secretary Weinberger; in addressing the Military Medical Commanders, he said:

I am directing Dr. Mayer aggressively to seek arrangements with community medical resources where they are available and where they meet our high quality standards. Medical services can be made more accessible to our families . . . They could include enrollment in Health Maintenace Organizations, preferred provider groups, fixed price contracts under which civilians insurors would pay for our beneficiaries health care. . . .

What I have described is a civilian and military partnership for excellence in medicine—to help ensure quality and to conserve our resources to apply them first and foremost to the well being of our troops. This partnership must be applied to our training programs as well.

The following observations about the military health Services system are offered in the hope they may assist the committee in its deliberations.

The MHSS is an excellent health care system. Considering the many constraints placed on the system, the leaders and members of the system are doing a fine job. Like any major system it can be improved.

The establishment of the National Disaster Medical System and its planned use of civilian hospitals in emergencies is an important and effective use of the nations health care system.

The MHSS is highly fragmented. There is a perception that it is a single system, when in reality it is four separate systems.

The MHSS is overextended, attempting to do too much with too few resources. It operates many more facilities than can be properly staffed. This problem is compounded by the seemingly endless rotation and reassignment of military personnel.

The MHSS devotes most of its attention and resources to the peacetime benefit mission to the detriment of the medical readiness mission.

The health care facility construction process is too costly and takes far too long to complete. In the civilian sector the programming, design, and construction of hospitals routinely takes one to two years. This process in the military takes eight to ten years.

In obtaining services from the civilian sector the MHSS has been extremely slow in taking advantage of the existing market place.

In the spirit of cooperation and with the desire to see an effective military-civilian partnership emerge, we in HCA, and I'm sure other civilian components, as well, are prepared to offer the following:

Enroll all HCA hospitals in the National Disaster Medical System.

Reduce CHAMPUS cost by agreeing to a prospective payment rate in our hospitals.

Enroll military beneficiaries in Health Maintenance Organizations (HMOs) and to offer Preferred Provider Organization (PPO) arrangements for care obtained in the civilian sector.

Negotiate firm fixed prices for supplemental care required by military hospitals for active duty members and others.

Develop and offer an alternative to the CHAMPUS program.

Program, design, and construct military health care facilities in a one to two year time frame.

Permit military physicians to train and treat military beneficiaries in HCA hospitals.

Compete for the contract operation of the existing nine Uniformed Service Treatment Facilities (USTFs) and for USTF status in other areas not currently served by MTFs or USTFs.

Develop a civilian alternative for each planned CONUS hospital construction project.

Provide primary and back-up ancillary and other support services (i.e., laboratory, laundry) to military hospitals.

Clearly, the military health care task is monumental. We are fortunate, however, that the defense health arena is one which has a definitive civilian alternative. Cooperating in a full military-civilian partnership, we can improve the medical readiness posture and provide for the delivery of the best possible health benefit to our military members and their families. Our soldiers, sailors, marines and airmen deserve nothing less. Some of the above ideas will optimize the national health resources and save considerable amounts of money. Our nation deserve to benefit from these savings.

WILLIAM Q. STURNER, M.D., F.A.C.P., D.M.J.,
North Providence, RI, October 7, 1985.

CHAIRMAN,
Senate Armed Forces Committee, Russell Senate Building, Washington, DC.

DEAR SIR: This letter is to strongly urge the full implementation of the Quality Assurance Program for the practice of medicine in the U.S. Military.

From my recent interviews of several instances of malpractice allegations, it is obvious that lack of communication, poor care, and other inadequacies are pervasive and continuing at Military Medical Centers, and when errors are committed, little or no accountability is forthcoming. This is at variance with procedures which have long existed in civilian medicine.

I urge the Committee to strongly recommend carrying out these standards which have been indicated, and to enforce those reviews, reprimands, and other penalties which may apply in cases of negligence and other misconduct.

Very truly,

WILLIAM Q. STURNER, M.D., F.A.C.P., D.M.J.

Senator WILSON. The hearing is adjourned.

[Whereupon at 1:15 p.m., the subcommittee adjourned, subject to the call of the Chair.]

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